NATIONAL FORUM ON HEALTH
FORUM NATIONAL SUR LA SANTÉ

Report on

Dialogue: Seeking Solutions to Health and Health Care

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CONFERENCE REPORT

The National Forum on Health was created to address the concerns of Canadians who are proud of their health care system but are worried about its costs, access and quality. As part of its mandate, the National Forum is committed to promoting a national dialogue with Canadians to chart the future and build on the fundamental values embedded in the principles of the Canada Health Act.

Since its launch, the National Forum has been examining specific issues, conducting broad-based public consultations and developing options for further investigation and discussion. This has been done through four working groups which are structured around the four themes of the Forum: Determinants of health, evidence-based decision making, values, and striking a balance.

OBJECTIVES OF THE CONFERENCE

Following on a series of community level, public consultations held across Canada, the National Forum held a Stakeholders Conference, *Seeking Solutions to Health and Health Care*, in Toronto on April 19-21, 1996. Conference participants were drawn from the health and health care communities across the country with representation from organizations and associations at the national, provincial, and community level. Approximately 200 participants attended the conference.

The objectives of the conference were:

- To present and discuss the key issues being addressed by the four working groups.
- To obtain meaningful, timely input from stakeholders on these issues.
- To capture new thinking and emerging issues.
- To understand and identify potential areas of convergence and divergence between views of the Forum, stakeholders and the public.

To achieve these objectives, the conference was structured as follows:

- Plenary presentations to share and situate the views and the work of the Forum to date.
- Three series of workshop sessions to provide an opportunity and channel for two-way dialogue, exchange and debate.
- Reports to plenary by participants, to highlight the scope and direction of small group discussions and to share personal reflections on specific issues and the conference as a whole.

This report contains highlights of the plenary sessions and key points from workshop group discussions about each conference question. The complete text of each of the summarized presentations and notes from each workshop group are included in the appendices of this report.

OPENING SESSION

The conference was officially opened by the Conference Chair, Judith Ritchie. Dr. Ritchie emphasized the importance of the conference in the consultative phase of the Forum's work. This dialogue with policy and decision makers, service providers, researchers and consumers would signal the completion of the initial phase of the Forum's work. From here, the Forum begins the process of synthesis and elaboration of options and directions for the future.

Tom Noseworthy, Chair of the Forum's Steering Committee, described the Forum's mandate and provided an overview of the work plan. Dr. Noseworthy outlined the public discussion process, and noted that the first phase of this process concludes with the conference. During the synthesis process, Forum members will carefully consider the views expressed during the conference, together with the conference briefs. The Forum will seek opportunities to test directions before final recommendations are presented to the Government.

Opening Address – The Honourable David Dingwall, Minister of Health
In welcoming participants to the National Forum on Health Dialogue, Mr. Dingwall stressed the importance of recognizing that the Forum's work will culminate in a report to the Government of Canada and will make a significant contribution to the future of the health care system and to the health of Canadians. The recommendations of the Forum are intended not only for government, but for the people of Canada.

The Minister reviewed the key characteristics of the current policy environment, including the need for all parties, especially federal and provincial governments, to work together with common aims; the federal commitment to stability of funding; and the non-negotiability of the principles of the *Canada Health Act*.

In terms of priorities, the Minister described several examples where the needs for services, the costs of service, and the structure or access to services were problematic. In this context, he spoke of women's health and the government's Centres of Excellence initiative; the needs of the aboriginal community for local access to health professionals; children's priorities, most notably reducing tobacco use among youth; and seniors and their access to health products and services, noting the related concern for increased drug

use and costs in Canada. He cited prevention and health promotion as essential components of the federal government's health strategy.

The Minister concluded his remarks by reviewing his expectations for the work of the Forum and the importance of this conference.

PLENARY SESSION I

The purpose of this plenary session was to briefly outline the work and directions of the Forum and each of its four working groups, as well as to set the stage for a discussion of conference questions within the context of health.

Determinants of Health – Marc Renaud
The aim of this group is to document how non-medical determinants impact on health, and to discern what policies could be put in place to improve the health of Canadians.

To understand these causal relationships in more depth as well as their implications for target population groups, the working group commissioned more than 30 papers from key experts across Canada. Recognizing that this is new policy ground, the working group asked these experts to provide examples of lessons and success stories on the non-medical determinants of health. This led the working group to pose questions to conference participants, and to seek their input on how they view the non-medical determinants of health. The working group wanted feedback on whether it was on the right track, what the priorities were, and how objectives could be achieved.

Values Group – Nuala Kenny
The values group will attempt to define what is meant by values, identify those values that are important to Canadians, and to determine their implications for public policy.

The health care system embodies values more than any other social structure. What do we know about what Canadians say is important to them as a society, and how do these things matter when we talk about the health care system? The input received by the working group will be synthesized into a set of Canadian values and compared against the values inherent in the *Canada Health Act*. The Forum may also make a recommendation about establishing a National Ethics Advisory Board.

The challenge for the Forum and for conference participants is to definine and understand what we mean by a word like *fair*, and to decide how to apply such a concept in decision making.

Striking a Balance – Tom Noseworthy
When the Forum first met, a dominant emerging theme was the need to consider the balance of resources both within the health care system and between the health care system and other areas of public policy. The working group on "Striking a Balance" will examine where, how and how much re-balancing needs to occur in order to maximize health outcomes. This group is exploring the issues of private/public financing, emerging models of health care delivery, including regionalization, and a number of issues associated with pharmaceuticals. The group will also provide its advice on the issue of balancing prevention and cure in the health care system.

Evidence Based Decision Making – Karen Gainer
The goal of this working group is to determine how to bring evidential standards into the decision-making process and change the culture in which health decisions are made. From providers to patients to managers and policy makers, the working group is interested in finding ways to ensure that decisions about health and health care are based on the best available evidence.

The group is also looking at the other incentives and interests in the system as well as the various kinds of evidence which shape decisions – some social, some political, some fiscal. While the group believes the ingredients and research base are in place for a strong health care system in Canada, policies need to change so that knowledge is used properly in making health choices.

Key Note Presentation – Seeking Solutions to Health – Louise Nadeau
According to Ms. Nadeau, the main question that needs to be answered has to do with the distinction between health and the health care delivery system. Dr. Richard Lessard described the goal as having good cars, but not necessarily good garages. At the same time, a major factor in health has to do with how we live our lives, how we deal with overpowering events and problems, how we were brought up and how we feel supported in our community. All these determinants of health are more important than the health care delivery system.

When we talk about factors that influence health, it is clear that we are in fact looking at a combination of factors. Essentially, we recognize that there is a causal link between income and health. But there are other factors, as well, including the environment, heredity and education.

Canadians are well aware that they have to work to achieve good health. They realize the importance of education, of being well informed, of a support network and of a healthy community. They know that we are each responsible for our own health and that as such our lifestyle choices are important (i.e. good nutrition, exercise, moderate drinking habits,

not smoking) and we must access health care services responsibly. However, when we look at what concerns Canadians, we get a different picture. They are preoccupied with illnesses, and the effect of illness on their health and on that of their loved ones. They are concerned about the restructuring of the health care system and the shift to community care. They are afraid of losing their health care system and they have a hard time making value choices.

There is a paradox. When you appeal to people's emotions, Canadians are concerned about the individual and illnesses. They want a solid health care delivery system that will be there for them, that will take care of them. But when you appeal to their reason, they focus on the common good and are concerned about health. They are looking for policies that value work, education, family and children. Given the challenges brought about by the reform that is starting to take shape, the only way we will be able to make changes in Canada is if we face, and overcome, our fears.

PLENARY SESSION II

This plenary set the stage for a discussion of conference questions within the context of health care.

Key Note Presentation – Seeking Solutions to Health Care – Nuala Kenny
Dr. Kenny described how the history of health care in Canada, with respect to:

(a) federal/provincial funding and system management,
(b) the emphasis on doctor/hospital-based care, and
(c) the enormous advances in human science and technology

has brought us to a place where the dependencies and expectations of Canadians collide with the costs associated with sustaining our current level of health care. It is not a matter of "who did what," but rather "we", socio-culturally, who have created the condition.

In this context, Dr. Kenny sees the fundamental questions as these:

1. What is the proper place for professionally delivered health care in the continuum of health? How can we ensure that our excellent quality of health care is sustained within a larger vision of health for Canadians?
2. Can we address whether or not health care needs are unique among other care needs? What are the implications for responsibility and accountability for Canadians' health?
3. What is "appropriate" medical care? In what way is "medical necessity" as opposed to "health necessity" to be defined?
4. What is "good" medical care? How does medical care relate to the larger concerns about the human and familial good of Canadians? In what ways do we put together

the demands of scientific medicine with personal demand for choice driven by personal values?

As we look to make policy choices, Dr. Kenny considers the overriding questions concerning good medical care within the Canadian health system as having to do with how to put science in the context of human good, and how to balance the extreme health care needs of the few over the health needs of the many.

HIGHLIGHTS FROM THE WORKSHOP GROUPS – CONFERENCE QUESTIONS

Participants were divided into 12 pre-assigned workshop groups within the context of the four Forum themes. Questions were developed for each theme to structure the discussions. These questions reflected the key points of debate for which the Forum sought stakeholders' input. In some groups, participants dealt in depth with a single question such as the potential place in Canada for a "regionalized" approach to health care delivery, while other working groups discussed all questions associated with a given theme.

The workshop groups, which included Forum members as participants, met for the balance of the morning and again in the afternoon following the key note speech on health care.

Where possible, discussions addressed both the health and health care dimensions of their topic questions.

Key points from the discussions about each question follow.

BALANCE (Groups 1 - 6)

Question 1. Balance Between Health and Other Social Programs

- There was general consensus across groups that the level of funding available for the health sector is about right, and that there is not much scope for further cuts. Any reallocation between health, education and other social programs should be outcome-oriented and based on the best possible evidence. Participants felt that better management of resources is needed in all three areas.

- Beyond the issue of how best to allocate the social pie is the question of whether the pie is big enough. Some participants suggested that from an economic perspective, we cannot afford not to invest in social programs. Deficit reduction has served as a rationale for government to reduce social spending, yet social programs have not

caused the deficit. There was also a sense that the media has played an important role in setting the current political agenda.

- Another dominant concern was the need for a "made-in-Canada" vision and policy framework to guide allocation of resources. The framework should have a national, holistic, long-term perspective, and should emphasize needs-based planning, accountability, affordability, and outcomes.

Question 2. Balance Within the Health Sector

- Shifts in the balance of resources within the health sector should be evidence-based and should promote the development of an integrated, seamless system of health services. While there is a rationale to move resources from institutional to community-based services, from cure to prevention, and from acute to chronic/palliative care, participants emphasized the need for an overall plan to guide reallocations. The plan should be long term (i.e. beyond the mandate of a particular government) and should pay particular attention to the groups and individuals who will be most affected by change.

- The key objectives which should guide reallocation include: maintenance of the *Canada Health Act* principles and their underlying values; better health outcomes; a reduction in health inequalities; a better balance between quality of life and duration of life; putting services closer to home; cost-effectiveness; continuous quality improvement; and care/respect for ethics.

- Primary care and home care are two key areas which need the immediate attention of policy makers. Primary care is often the first point of contact for individuals and can play an important role in health promotion, disease prevention, and more generally, population health. However, primary care has to become more client-focused and multi-disciplinary. The shift to home care also needs attention because of its potential to affect quality of life. Policy makers should ensure that adequate resources are provided for home care and that the role of informal/volunteer caregivers is recognized.

Question 3. Public/Private Financing

- Participants felt that the current balance of public and private financing is sub-optimal, and that the public level may be getting too low to ensure quality and accessibility. Key issues which should be addressed include the definition of comprehensiveness (what's in and what's out) based on evidence, the incentives to shift costs from public to private sources, and defining quality of services which Canadians can expect from Medicare.

- Participants agreed that respect for the *Canada Health Act* principles should be the starting point of any discussion of the balance in public/private financing. While rejecting the idea that there needs to be more private money in the system, participants felt that certain incentives should be changed so that funding follows the consumer rather than the provider, and that consumers need to have more input in decision making. They also agreed that equity, efficiency and effectiveness should guide the public/private allocation of resources.

- The definition of "comprehensiveness" should be flexible over time and evidence-based, and should allow for the exercise of professional judgement and incorporate patient values and preferences. Participants were more comfortable with multiple-screen models than with list-based approaches such as was used in the state of Oregon. They also felt that private insurance could continue to play a useful role in supplementing, but not competing with, coverage provided by the public system.

- One group noted the "irreversibility" of increased private funding, and the need to consider the implication of moving from private not-for-profit towards for-profit providers. A variety of views were expressed as to whether health care is or is not a "commodity". It was also suggested that the federal and provincial governments need to work together to maintain an appropriate balance of public and private funding. Efforts should be directed towards decreasing overall utilization, but more public funding should not be ruled out.

Question 4. Organization of Health Services

- On the issue of planned market models as practiced in some European countries, participants agreed that a thorough evaluation must take place before considering their adoption in the Canadian context. Concerns were raised about the applicability of internal market approaches in Canadian settings, which are more rural and less densely populated than European countries. In addition, internal markets may not be consistent with Canadian values.

- Some participants felt that some aspects of planned markets were already in place in certain Canadian jurisdictions, but that there is a need to balance this conservative agenda with compassion. Some felt market-driven approaches to delivering health care could offer some benefits for the system, but that such a move would not be a panacea.

- On the issue of regionalization, participants identified a number of additional structural changes which need to be implemented. These include: reductions and restructuring of health ministries (both federal and provincial); population-based funding for regions; primary care reform; development of better information systems;

rethinking the composition of regional boards; transferring authority from the province to the region; and establishing linkages with teaching and research. There is a general concern that rhetoric is not being backed with action, and that there is a lack of stewardship.

- While there remain some barriers to making further structural changes, some participants felt that regionalization will likely result in a more responsive, integrated, accountable and flexible system which will provide for better continuity of care and more direct involvement of the public in decision making. Other participants thought that regionalization should not be viewed as a panacea and that provinces would do well to step back and evaluate the latest wave of reforms before implementing a new wave of changes.

Question 5. Pharmaceuticals

- Participants perceived the current balance of power and accountability in the pharmaceutical sector to be complex and somewhat inappropriate. Issues requiring attention include cost, utilization, prescribing practices, drug advertising, access, data availability and quality, the systemic culture of health care (stove-pipe, quick fix), perverse incentives, the behaviour of consumers, the place of alternative therapies, and drug safety.

- Participants proposed several "adjustments" to pharmaceutical/health policy in Canada:
    - expand coverage of the *Canada Health Act* to include all effective care, including drug therapy and alternative medicines;
    - change remuneration systems for physicians and pharmacists to realign incentives and reflect "cognitive" reimbursement (i.e. pay for provision of advice, even if no drug is prescribed or dispensed)
    - improve evidence availability and quality (e.g. common database with rules of evidence) and communicate "error signals" to decision-makers in a timely way;
    - establish a national, arm's length medicine review/control organization to operate drug approval system, and track drug utilization, safety and effectiveness; also, consider harmonizing Canada's drug approval process with that of other countries;
    - reform primary care system to generate a more appropriate mix of providers and resources to keep population groups healthy;
    - expand national standards for drug advertising, to reflect the shift to evidence-based medicine;
    - develop a national formulary to avoid costly duplication of provincial formularies;

develop initiatives to educate consumers on the use and cost of drugs.

- Various views were expressed about the impact which the extension of patent protection for drugs under Bill C-91 has had on drug costs. Some suggested longer patent protection is a significant health care cost driver whereas others contended that it is not. Some participants felt that the Patented Medicine Prices Review Board has effectively controlled drug price increases, but should be given more teeth. Concerns that the pharmaceutical industry had not lived up to its research commitments under Bill C-91 were also raised.

DETERMINANTS OF HEALTH (Groups 7 & 8)

Question 6. Determinants of Health

- The purpose of the discussion was: to examine the level of agreement and common understanding of the determinants of health approach, to define the priorities for action and to identify the conditions and best ways to implement this broader approach.

- There was a high level of acceptance for the determinants of health approach and agreement on the many factors that impact on health – employment/work, economics and income security, personal health practices such as healthy eating, smoking, substance abuse and use of medication, self-esteem, social support, etc.

- Several priorities for action were identified:
  - National Forum on Health should "walk the talk" on the determinants of health approach in all areas of examination, including the review of the financing/funding of the system – e.g. write a report on the public and private financing of the system to support and promote health.

  - The National Forum on Health should recommend the establishment of a health information system to support decision making on the allocation of resources within the context of the determinants of health approach, and to build on the current momentum of supporting population health research. Accountability for outcomes must be attached to programs. Equity should be used as a value to guide resource allocation in the assignment of priorities.

  - Regarding the definition of priority groups, there was extensive discussion about whether resources should be allocated to support specific groups at risk or for the population as a whole. Children and youth at risk, in the

context of their families, were singled out as important. However, there was some reluctance to limit attention strictly to this group because of the issue of equity and the needs of other groups such as Aboriginals, the mentally ill, people with disability, seniors and the economically disadvantaged. There is a need to remove "isms" from language and culture.

Employment policies and a re-engineering of the workplace to foster health were seen as a priority based on partnerships among government, business and communities. This would include, for example, the creation of family-friendly workplace policies such as job sharing and child care support.

- The groups then focused on ways to achieve these priorities and to create conditions that promote health. Intersectoral collaboration and partnerships are critical to develop integrated solutions. There is a need to develop a common language. "Determinants of health" is not a concept common to all sectors. Health should be put on all agendas – media, education, corrections, economic/finance, etc. Community participation and responsibility are key to success. Although partnerships are important, they are not always the panacea. It is important to identify the areas where collaboration is necessary, and where individual action will not be effective. Finally, the role of government should be one of providing leadership, vision and regulatory support – not service delivery.

EVIDENCE-BASED DECISION MAKING (Groups 9 & 10)

Question 7. Culture of Evidence-based Decision Making

- There was strong support for building a culture of evidence-based decision making. The culture of evidence needs to be open, accessible, understandable and transparent. It must value inclusiveness and promote the creation of new methodologies which feature better linkages between the generation of evidence and its use. It also assumes enhanced outcomes and it recognizes its own limitations, rather than creating a new "tyranny".

- The underlying principle is that decisions should be based on evidence, i.e., decision-makers should be explicit about their decision-making processes to allow for discussion, challenging of decisions, and learning from mistakes.

- The new culture should be broad and inclusive, and should recognize the need for intersectoral cooperation across all jurisdictions, at all levels, and with the public.

- Generation of information needs to be an accepted and integral part of the health system. We need consistency and comparability of both processes and outcomes so that we can compare "apples to apples" within regions and across Canada.

- In moving to a culture of evidence-based decision making, a more balanced (quantity/ quality) approach to collecting evidence is needed, subject to values, cultural expectations, norms, circumstances, etc.

- There was concern that the current focus on economics/fiscal realities may be driving the collection of evidence, but it should not be the only focus (i.e. it is important also to collect qualitative research data, health outcomes data).

- Evidence should also be disseminated effectively. Barriers to evidence-based decision making in our system must be recognized (e.g. fear, professional turf, values, resistance to change).

- There was recognition that evidence-based decision making is a difficult process to implement. There needs to be a major education effort at all levels in the health system; fear of loss of employment, and provider control, e.g., physicians needs to be addressed. This requires an inclusive process which ensures that human resources continue to be valued.

Question 8. What is Evidence?

On the question of what constitutes evidence, and whether the standards of evidence are variable depending on culture or one's view of health, the following key messages were highlighted:

- Evidence was defined as the best available information upon which to make decisions. Evidence is one important input into the decision-making process; other sources of information are judgement and intuition, costs and policies.

- That there are different kinds and levels of evidence, both for health and health care, should be recognized. The application of evidence to decision-making may vary with current priorities and values. There are varied and multiple levels of evidence; it is much more than randomized controlled trials. One also has to be able to compare the types of evidence produced – e.g. assessing a drug therapy versus a surgical treatment.

- Evaluation of evidence is a complex question. We must ask: "For whom, under what circumstances, and relating to what issues?"

- Interpretation of evidence is personal and can ultimately vary with the culture of the day. People make decisions on the basis of belief systems (fears, values, turf, resistance to change). Personal factors affect whether information is accepted as evidence and will affect the relative weight given to evidence.

- We must strive to continually improve the quality of evidence. We should build models/frameworks to ensure that we value non-traditional or previously-valued evidence (e.g. from other cultures).

- New technologies and approaches that are promising but have not been evaluated should go to trial as early as possible, and should be evaluated with a broad view of costs and benefits (e.g. quality of life issues). The new policies and structures should be evaluated prior to implementation.

- A consistent evaluation process should be applied to all practices and policies (e.g. new and established Western medical practices and alternative therapies). The evaluation of health methodologies from various cultures should reflect those cultural values. Alternative/ complementary therapies might be publicly funded if they are proven effective. All therapies should be objectively evaluated with fairness as a criterion; alternative therapies should be considered as a basis for learning.

- Regulation of therapies is desirable, particularly where outcomes are potentially harmful. However, it would be useful to examine whether there are ways other than regulation to prevent harmful policies/practices.

Question 9. Health Information Infrastructure

The groups agreed on the importance of quality information on which to base health decisions. In terms of the health information infrastructure needed to support evidence-based decision making, the following ideas were presented:

- The health information infrastructure should have the following characteristics: national, person-oriented, integrated, affordable, confidential, accessible, and cross-sectoral.

- The groups questioned whether consumers want to be equal partners in the decision-making process, however, there was support for a national information infrastructure which contains information accessible by consumers/patients on a wide range of health conditions and it was stressed that it should be user-friendly.

- It is important that a national information system provides timely data, and that it can

link different databases and aggregate information in a variety of ways to meet the needs of patients, providers, and policy makers. The system should also provide a communication link between provinces. It should also be responsible for sustaining a national health survey.

- National standards are needed, so that there is a way of assessing the health reforms under way and structural changes to the health system.

- It was also suggested to use administrative systems to support health promotion education, e.g., sending out information packages to people diagnosed with certain conditions or to encourage preventative screening (e.g. mammograms for women over 50).

VALUES (Groups 11 & 12)

Question 10. Values and Principles

- A number of participants identified the following as important values or principles in relation to the health care system: a healthy population, equality of access for individuals and quality of care. Comprehensiveness and respect for traditional healing values (First Nations) were also noted.

- A majority of participants discussed the necessity of including individual responsibility, accountability and the importance of public participation as important values for a wider determinants of health approach. A discussion also ensued on the value of personal autonomy balanced by personal responsibility for one's own behaviour.

- Participants felt that conflict could develop among or between different values, as well as from the differing interpretations of the term 'values'. The potential conflict between individual responsibility and societal responsibility was also identified. Moreover, the principle of equitable shares for groups may be a function of defining the ability of individuals to meet their own needs.

- There was also some concern that the listing of values presented to the groups could not adequately be used to answer the question "Why are some people healthy and others not?" The opinion was also voiced that the question itself requires additional thought prior to being in a position to articulate the values at play. The groups also noted, however, the role and importance of values in the work of the National Forum and that the Forum needs to articulate how values will affect decision making and policy development so that the general public will understand the process.

Recommendations at the end of the day must necessarily reflect the values held by Canadians.

Question 11. Right to Health Care / Allocation of Resources / Government Priorities

- This question was designed in large part to engage participants in a discussion of whether Canadians do have a right to health care and how this right, if so identified, is either qualified or limited, conditional or unconditional.

- The distinction and conflict between individual and collective rights were also identified as framing the discussion.

- Some participants asserted that there is some entitlement to a notion of 'rights' while others preferred to characterize it as a 'duty to provide'.

- In short, discussion focused on definitional issues and subsequently on how one would qualify this right or duty and the attendant implications of each.

- A right to "quality services" and "best health services available" were identified more frequently than a right to "basic services", though many participants felt that the National Forum should assist in defining these terms more precisely. A number of participants noted that as a society, Canadians have increasingly moved away from the notion of "basic" services.

- Many participants noted that tradeoffs must be made and that public participation and consultation should necessarily be involved in determining those tradeoffs. Also, these tradeoffs should be premised on finding the best balance and allocation between meeting needs and improving overall health and quality of life.

Question 12. Allocation of Resources / Palliative Care-Acute Care / Fairness in Waiting Lists

- Questions on issues of resource allocation were designed to engage participants to examine the basis or criteria required for making difficult allocation decisions. The issue of examining possible criteria for priorizing waiting lists led many to assert that priorization should be linked to the right to services continuum discussed earlier.

- Some participants identified evidence, community input, community values, examination of consequences and intuition as criteria required by decision-makers. Moreover, resource allocation decisions should be premised on asking individuals the correct question(s) before proceeding, otherwise, the process is compromised. Also,

the criteria must be defined and articulated for a thorough debate and public understanding of the issues.

- Resources could be shifted from certain sectors – e.g. acute care to education – but only if there is an evidentiary basis for doing so. A key message coming from the discussion in both groups is the role and importance of public input into the resource allocation process.

- Re-allocation within the health system should target problem areas such as the increasing cost of pharmaceuticals.

Question 13. Inequalities / Resources for Health – Health Care

- Questions pertaining to inequalities in health care invariably turned to a discussion of public and private financing and the impact that a two- or multi-tiered health care system would have on Canadians.

- There was general consensus that despite the inequalities that exist in our current system, it is still a defining Canadian feature and efforts to privatize the health care system should be resisted. However, to keep our system truly universal, we will have to examine what we mean by core and fundamental or essential services.

- The issue is not money, but the core values of Canadians.

- Participants noted that health is a value unlike other commodities and societal characteristics, and deserves separate consideration.

- Participants noted their pride in the existing system but were unequivocal that its deficiencies – e.g. inequality of access – should be remedied in preference to a move to a more privatized system. A multi-tiered system would have negative impacts on the quality of health care, level of research and training.

- The health system should be expanded to include some services which are preventive in nature.

- There should be some "right to the pursuit of health", hence society needs to make some investment so individuals can make that choice.

- Some participants felt that society has disproportionally invested in health care and ought to invest more in the determinants of health – education, nutrition, etc. Also, if we are to increase funds for prevention and health promotion programs, the question arises as to how active/interventionist we should be.

PLENARY SESSION III

At 5:00 pm, participants reconvened in plenary to hear reports from four participant rapporteurs, whose task was to report briefly on the discussions of all groups under a given theme. While informal in nature and presentation, these reports provided attendees with an opportunity to hear the views of colleagues who had worked on other themes over the course of the day.

PLENARY SESSION IV

Future Trends & Issues – Lynn Smith
The question posed to the conference attendees was: What do we believe the future holds? What does this group want the future to bring – what is its vision?

Lynn Smith identified a number of trends and assumptions that emerged from the previous day's session. These trends included support for the *Canada Health Act* with its five principles, coupled with the values of fairness and compassion; and policy formation guided by the goals of a healthy population, equality of access for individuals, and quality of care. Other trends included pressure to privatize the system in all areas and on-going resistance to this pressure, combined with continued fiscal restraint; shifting emphasis to health from health care while not destroying the health care system; and a wish that decisions be based on evidence with an understanding of the underlying value choices. Canadians will continue to value pluralism and respect of diversity, support quality, rational and inclusive decision making, and recognize the challenges in bringing about change.

Could actions by government affect these assumptions and trends? If you were a Forum member, what would you argue for, if you were trying to come up with a few key recommendations? These questions set the framework for the morning's discussion groups.

HIGHLIGHTS FROM THE WORKSHOP GROUPS – FUTURE TRENDS AND ISSUES

While Saturday's working groups were structured around the four Forum themes, Sunday's groups all shared the same questions: the synthesis of issues thus far, the issues that surfaced as most urgent for the Forum's attention, and the new emerging concepts, practices and ideas aboutof which the Forum should be aware. As in the Saturday groups,

the discussion highlights from each group were captured and are included in the appendices to this report.

The purpose of the Sunday session was to bring synthesis to Saturday's discussions and to look at future trends and issues in health and health care. Conference participants were asked at the outset to consider what they thought the future should hold for the health system in Canada.

Issues

A number of issues were identified by conference participants, including:

- There is a lack of clear definition with respect to key elements in the health dialogue, particularly the five principles contained in the *Canada Health Act*.
- The appropriate role for the private sector in the health care system has yet to be determined.
- There are inadequate accountability structures in the health care system.
- There should be a more ordered allocation of resources within the health care system.
- There should be greater coordination in the policy decision process between the health and other social sectors.
- There is an apparent paradox between Canadians supporting a strong federal involvement in health, and Canadians favouring regionalization, decentralization, local autonomy and needs-based services.
- Health care is shifting from an institutional base to a community base before the community base is prepared for that shift.
- There is a political reality that decisions are often made within the health system for other than evidence-based reasons.
- There is a fragmentation and lack of sharing of information within the health system.
- There is a potential for conflict between "evidence" and "values" in the health reform dialogue.
- There is a fear that in emphasizing health, we might weaken the health care system.

Change

Specific proposals for change developed in Sunday working groups and brought forward by rapporteurs included:

- Revisit and revise the *Canada Health Act*. Revisions would serve to clarify or operationalize the definitions of the five principles contained in the Act.
- Either through changes to the CHA or through some other administrative instrument(s): adopt a vision and values for health and health care in Canada; introduce the concept of population health; set limitations to health care; and confirm the essential role of the federal government in the health sector.
- Create a mechanism that would allow for an ongoing dialogue/forum on health reform.
- Strategically allocate resources within the health system, including a set percentage on health promotion.
- Ensure that the review of Bill C-91 makes a full assessment of all costs and benefits associated with longer patent protection for drugs.
- Examine actual cost increases in health.
- Create a single point of entry to the health care system.
- Create a solid, integrated, evidence-based information system.
- Review who are, and who should be, the gatekeepers of the health system.

Participants also identified specific ways in which changes could/should be introduced. These include:

- Introduce a more rational and inclusive decision-making process to the health care system.
- Increase collaboration and coordination between levels of government (federal-provincial/territorial) and among sectors (health, finance, human resources).
- Provide health consumers and clients with greater control in decision-making processes.

- Delineate to a greater degree the roles of public and private health-care providers.
- Recognize the inevitability of trade-offs in policy making.
- Recognize the rational/emotional nature of human beings in making policy decisions.

PLENARY SESSION V

The final plenary featured a panel discussion of four participants who had circulated among groups during the morning. Their task was to report both their observation of group discussions and their personal reflections on the conference as a whole. The presenters and highlights of their comments were as follows:

Colin McMillan – Canadian Medical Association
Dr. McMillan's remarks highlighted a number of the key paradoxes / decisions that Canadians will need to resolve. For example, he spoke of people's commitment to the principles of the *Canada Health Act* and the need to discuss and clarify "comprehensiveness". On the other hand, many people are said to favour decentralization, regionalization, local autonomy and needs-based services. The issue will be how to balance a strong federal system, including a redefined *Canada Health Act*, with the preference for devolution of structure authority and resources.

Lil Selby – Canadian Mental Health Association
In her report of working group discussions, Ms. Selby shared her observation that there seemed to be broadly shared elements of a vision of the future, including: accountability, accessibility, moving forward from health care to health and coordination of services to a single point of entry.

Ms. Selby also noted the emphasis of groups on:

- stability in funding
- well measured efficiency of delivery
- availability of good data for decision making
- the need for a broad, national vision of health and health care
- research on service and service delivery
- a clear analysis of regionalization
- evaluation of policy changes vis-à-vis expected outcomes
- strategic use of educational institutions in the context of determinants of health.

Beyond this, Ms. Selby spoke to the challenge that the mentally ill represent for health policy and the Forum. She urged participants to be particularly sensitive to the plight and

needs of the mentally ill, so that they will have a place in the system in the future and a voice in the policy-shaping process.

Renaldo Battista – Conseil d'évaluation des technologies de la santé
Dr. Battista spoke of a number of key issues under discussion including, for example, that health reform should not be fiscally driven; that health and health care are complimentary concepts, and that operational definitions are required to shape practical policy change; and that there is a broadly felt need for a rational framework or system of health within which people can be involved in the decision process at the local level.

In his personal observations, Dr. Battista commented on the size and complexity of the issues, and in particular the challenge of "operationalizing" the findings coming from the work and knowledge on determinants of health. He also emphasized the concept of regionalization, stressing that this was a relatively recent development which requires a clear understanding of benefits, costs, and risks before further extension of the approach.

Charlotte Gray – Health Media
Ms. Gray noted that the point of strong consensus across groups was the need for a national structure to continue the dialogue on health and health care in Canada. Related to this is the paradox that while most stakeholders hold strongly to the CHA and its principles, most would argue for the need to refine and re-define these principles. A second key issue concerns the transitional nature of the health care system at this time and the fear of many Canadians that they are witnessing change without a centre, and this is cause for concern. Finally, Ms. Gray noted that much of the energy in discussions has its source in the frustrations of the past; that what's been said at the conference has been said for 15 years. Consequently, the Forum and the conference have raised expectations and she strongly urged the Forum to recognize and respond to the need for action.

APPENDIX A

Speaking Notes
for
The Honourable David Dingwall
Minister of Health

NATIONAL FORUM ON HEALTH DIALOGUE:
Seeking Solutions to Health and Health Care
Toronto, Ontario
April 19, 1996

Good evening, health care professionals, representatives of health organizations, distinguished guests, ladies and gentlemen.

I am delighted to be here, and I want to take this opportunity to express my appreciation to the members of the National Forum on Health, who have been working on a number of important public policy issues related to health and health care in this country.

As Vice-Chair of the Forum, I also bring greetings from the Prime Minister, who, as you know, is the chairperson.

It is important to recognize that the Forum's work will culminate in a report to the Government of Canada at the end of the year. Its recommendations will provide an important legacy -- not only for governments -- but for the people of Canada.

I want to thank members of the Forum who have contributed so much to the debate thus far. I welcome and thank all of you for participating in this process. I am certain that as key decision makers you, too, will make a significant contribution to the future of our health care system.

The people here tonight come from a variety of sectors and wear a variety of hats. However, whether we are consumers or union members, professionals or academics, members of government, the private sector or volunteers, we share a common purpose: we all want to improve the health of Canadians.

We are seeking solutions. We are looking for practical but creative ways to deliver effective health care that is both high quality and affordable.

The title of this conference, *Seeking Solutions to Health and Health Care*, clearly describes the challenge we face. The current fiscal climate demands that we find solutions to problems in the health care system. But health is more than health care. We must work together to discover ways to prevent illness and promote health for all Canadians.

As the Minister responsible for what is commonly referred to as "Medicare", I am also concerned about the health of our population. I believe it is important for all stakeholders,

volunteers, organizations, the private sector and governments at every level to work together to resolve issues affecting public policy.

When I was appointed Minister of Health, the Prime Minister asked me to foster a working relationship with the provincial governments. At Rideau Hall, at my swearing in, I announced my intention to work cooperatively with my provincial counterparts. A few days after my appointment, I met with several provincial Ministers of Health to discuss a variety of issues. It must be said that a good many of our provincial governments are attempting to modernize their health care systems and have received little credit for it.

Many of us perceive the health care system as a ten-storey building with doctors, nurses, dietitians, physiotherapists, nurses' aides, huge parking lots and cafeterias. Some Canadians believe that represents health care in our country. But, as key decision makers, you know that is not the extent of our health care system.

As provinces try to grapple with difficult decisions, I do not buy the argument that the quality of our health care system is declining. In many jurisdictions, the quality of health care is improving, and I think we should recognize that. Not that there are no difficulties or pain, but there is a legitimate intent by our provincial governments to improve and to enhance the quality of our health care.

In working with the provinces, I do not think that everything is going to be wonderful. We are going to have differences of opinion -- the blood system, drugs, policy issues, home care, palliative care, or fitness -- there are going to be differences on a whole range of issues. But we have to work together to try to resolve them.

I am not prepared to put forward constitutional arguments related to health care, but should anyone, provinces included, want to, I would be prepared to debate them. In my mind there is a clear role for the national government to play in health care and health of Canadians.

I believe that we should come together as stakeholders at the provincial/territorial and federal level of government to resolve the issues before us.

A measure of good faith was demonstrated when I met with provincial ministers to discuss the CHST -- the Canada Health and Social Transfer. They asked for predictability; they got

predictability. They asked for a cash floor; they got a cash floor. They asked for a minimum of three years; they got five years. And they got $25.1 billion each and every year for five years with an escalating clause for the last three years.

The Government of Canada clearly delivered, and I think this was an important first step on our part as a national government as we try to move into a partnership role with provincial governments. That doesn't mean the provinces are going to stop asking for more movement by the federal government. I understand that.

Tonight, I have come to reaffirm the Government of Canada's position in terms of the five principles of the *Canada Health Act*. Those principles can be debated but, as I have said to my provincial colleagues and as I have said to the national media: the principles of the *Canada Health Act* are not negotiable. That is my clear position, and it must be understood.

At the national level, prevention and health promotion are essential components of our health strategy. Cooperation with the provinces and various stakeholders, whether in nutrition, fitness, environmental health, jobs, or other areas, plays an important role in population health.

The other day, a group of citizens with whom I was meeting asked me about job creation and its effect on the health care system in this country. It has enormous impact and I don't think we can ignore it.

As the Minister of Health one of my primary concerns is tobacco. After taking over the health portfolio and meeting with different groups across the country, including the Cancer Society and the Lung Association, I am more aware that smoking is a substantial problem in this country.

Tobacco use costs the Canadian economy $11 billion per year -- $3.5 billion in health care costs and the remainder in lost productivity. That is a lot of money. More important, is the increasing number of young people who are consuming tobacco products, particularly young women. I believe the national government, in co-operation with provincial governments and stakeholders, has an obligation, to take action. We have a fiduciary obligation to our health care system, and to these young people, to reduce the consumption of tobacco products.

As Minister of Health, I have a few hurdles to overcome; namely, a decision of the Supreme Court of Canada that the Minister of Justice and I must face squarely. I will be preparing a comprehensive package to address issues of access, promotion, and products. But I will only do so when I have comprehensive information and evidence to carry us through.

I don't want the Supreme Court of Canada to find whatever actions we take unconstitutional. Tobacco is an important priority for this government, and we hope to move on it very soon.

Another major priority in this country must be the issue of women's health. Women are the major users of the health care system and we must resolve some of the difficulties they face.

I will soon be announcing the creation of Centres of Excellence in Women's Health. In making my decision on these Centres I want to be certain they are going to be able to produce real deliverables. I also intend to move forward with legislation on New Reproductive Technologies. A Royal Commission on this subject proposed many recommendations, and I hope to be in a position to address some of those soon.

In August, I will be hosting a Canada-U.S forum with the U.S. Secretary of Health, Donna Shalala . The Forum will examine a variety of concerns: breast cancer, cardiovascular diseases, fitness, obesity, the misuse of prescription drugs, and substance abuse -- a whole host of issues which have a profound and immediate effect on women in this country.

Aboriginal health is another significant and growing concern for the federal government, provincial governments and Aboriginal communities themselves. We have talked not only about the transfer of health care to First Nations, but also about ways in which we can upgrade the human resource element of Aboriginal communities in terms of doctors, nurses and other health care professionals. I hope that during your deliberations at this conference you will suggest ways in which we can further our objectives related to Aboriginal health.

With respect to children, this government wants to work with the provinces and stakeholders on issues affecting children and youth -- smoking, substance abuse, nutrition, obesity, fitness. They are all important to young people in this country.

As is mental health and what it means to Canadians and what it means to families.

We will have to give greater credence in terms of how we deal with issues related to seniors. And palliative care is a particular concern for me. This can be a very difficult subject on which to engage individuals. As professionals, you may not necessarily find it easy, but you have learned to deal with this subject. For most Canadians, however, palliative care means dying, it means death and people are not comfortable with that.

But the issue of palliative care is important in terms of developing a framework for aging. In mid-June, I will be attending a conference of federal/provincial/provincial ministers responsible for seniors in New Brunswick. We will be discussing and putting in place just such a framework.

Seniors are a formidable force in this country. We must be prudent in the way in which governments move -- not only in terms of their health care, but also in terms of other issues which affect them: pensions, access to facilities, their mental and physical well-being.

Two other areas of major concern to me are drugs and medical research.

Prescription drugs in this country are quite costly, whether generic or brand name drugs, and I know both interests are represented here tonight. Drugs are one of the cost drivers of the health care system across this country although the Patented Medicine Prices Review Board has been effective in terms of ensuring that manufacturers' prices for patented drugs have not gone up by more than the Consumer Price Index.

I have expressed concern, however, both publicly and privately, about the difficulties the pharmaceutical manufacturers have had in meeting the commitments they made for research funding. But I am sure we will soon be able to resolve these difficulties in a favourable way.

Drug usage is another substantive issue which needs our attention. I have been informed that drug usage in this country increases approximately 14 per cent per year. That is a substantial amount, both in terms of cost and effects on people in this country. In my travels, I meet with seniors and others who are worried about the quantities of prescription medication on the market. We need your help in seeking solutions to this problem. We will want to ensure that we distribute all the available information on usage so Canadians have an opportunity to examine this important subject.

I will be meeting with all the provincial and territorial Ministers of Health next week in Ottawa to talk about the governance of Canada's blood system and I'm certain that a variety of other issues will arise, including the subject of drug use and medication.

Our nation is blessed with some of the greatest researchers in the world. In its recent budget, the Government of Canada provided $65 million for a Health Services Research Fund that will enable provincial governments, health institutions and the private sector to work in partnership to bring evidence-based research into the system.

Canada boasts a significant international reputation in the health care field, and we have to take advantage of that in seeking domestic and international partners. With the Medical Research Council, we are going to seek out international opportunities to cooperate in both doing and selling our research.

It is also important that we take our research and present it in such a way that Canadians understand what it is about. Volumes of material exist, but the findings are not easily communicated to the public or to health professionals across this country. There is an obligation on the part of governments to ensure that we disseminate as much of that research as possible.

In conclusion, I want to emphasize your importance to the Forum's process. I have asked members of the Forum to complete deliberations and provide a report to me at the end of this year. I look forward to their recommendations. They will help not only the federal government, but provincial governments, and all our citizens. The recommendations will have far-reaching effects on our health care system and on the health of our population. As a country and as a people, we will be able to stand proudly and say, not only do we have the best health care system in the world, but we are going to continue to have the best health care system in the world.

Thank you.

APPENDIX B

PRESENTATIONS ON CONFERENCE THEMES

DETERMINANTS OF HEALTH - MARC RENAUD

I've been asked to report briefly on the work of the group, and outline what we're looking for from you during this conference. Our aim is to document what can be done to act on the non-medical determinants of health and, from there, to determine what policies can be put in place to improve the health of Canadians.

We've come a long way during the last decade, in defining health and in determining what makes us healthy human beings. We've known for a long time, by studying the relationship between variables, that social factors and health are correlated. It's not news, for instance, that the more affluent and better educated the individual, the healthier that individual is likely to be. On average, countries with higher average incomes that apportion that income well have a healthier population than countries with equally high incomes that apportion their income poorly.

In the last ten years, we've learned that the correlations are probably causal. In other words, we're almost certain that there are social, economic and cultural determinants of health, just as there are genetic determinants or determinants linked to health care delivery.

For example, we know about the correlation between health and socioeconomic factors; the higher one's social status, the better the chances of leading a long and healthy life. We cannot use poor lifestyle choices by the disadvantaged to explain the correlation.

Second, we are starting to understand how these social determinants affect the body, causing illness and, eventually, death. We've learned about these biological pathways as a result of state-of-the-art biomedical research, particularly in the areas of immunology, endocrinology and neurology.

Third, we've known for the past ten years that human beings can improve their health by changing their lifestyle. Let me tell you about two striking examples. In a span of 30 years, Japan has increased the life expectancy of its population dramatically; the population of Eastern Europe, on the other hand, has seen just as dramatic a reduction in life expectancy during the past 20 years.

That's what we know. You're going to ask me, "So what?" What do we do with this knowledge? That's the problem. We don't know at this stage how this knowledge translates into action. Where do we invest if our goal is to improve the health of Canadians? Investments in hospitals, drugs, and physicians are concrete; investments in social programs, in children, in job sharing – that's more intangible. We can't be sure of the results.

That's why the group on determinants of health of the National Forum on Health decided to look at this question in particular. We asked 30 recognized Canadian experts to submit position papers. We asked them to tell us about children, youth, adults and seniors. Some were asked to concentrate on

macro-social issues, for example how to increase children's resiliency, how to facilitate the transition from school to the workplace for young Canadians, how to provide support to retired citizens (including those who retire early, which is a popular option nowadays).

Some of the papers we received outlined a macro view. Others focused more on specific issues – suicide, abuse and negligence of children and the elderly. We asked experts to concentrate on specific problems, on target populations, but also in particular contexts. We said to Canada's top experts: Show us how education can change people's lives and improve their health. Show us how the work environment can have a positive impact on health. Show us how mobilizing a community can benefit people's lives. Show us how national fiscal policies can make a difference.

Most of the papers are in, and they constitute an extraordinary knowledge base. We've learned, for example, that neural development in childhood determines the level of health in adulthood. In other words, the neural pathways developed at a young age will later determine how well the adult deals with the stresses of everyday life, and therefore how healthy that adult will be. We've learned that programs, from pre-natal to pre-school, have had a beneficial effect on children. And we've learned that, as a result of the globalization of our economy, the workplace is being subjected to a sea-change. There will be fewer and fewer jobs for young people. Employees will be asked to retire early. Yet in certain regions, in certain countries, in certain industries, we've found ways to valorize work and thereby improve the health of workers.

What we've done, then, is compile success stories; and as we reflect on these success stories, we will be able to determine what policies we can put in place for the future. Needless to say, solutions transcend the mandates of ministries of health; in fact, every level of government has a role to play.

Briefly, what do we expect from you? First, we'd like you to tell us whether we're heading in the right direction. We'd like to know whether you think the Forum should emphasize action based on determinants of health. Next, we'd like you to tell us your priorities. We're talking about children, adults, seniors – where do we start? And finally, we'd like to know how you would tackle the problem.

We're breaking new ground, and we don't have all the answers yet. I was very pleased to hear Minister Dingwall speak about population health yesterday. It was the first time I had heard a politician say that population health is every bit as important as health care service delivery.

There's an old proverb: It's not easy to find a black cat in a darkened room. But if we don't look, we won't find...

VALUES - NUALA KENNY

I think my personal background as a paediatrician, health administrator and health educator, now a physician whose obligation in large part is education into ethical matters in health care, and the fact that I'm a Roman Catholic Sister, all made me a natural choice to be on the values committee of the Forum. And I think by default I became the chair.

I share Marc's experience of what we've done over the last 18 or 19 months. It has been an enormous learning opportunity for those of us both on the Forum and on my own particular committee on values, and to try to compact that down to give you some sense of what this means is really quite difficult.

My pedagogic educational background would say, if I can't say it simply I can't say it at all, so I would start by just reminding you that the committee I chair is the values committee. And there are times in the last year, when I have been speaking publicly, when I have been able to say to folks "values" are in. Everybody's talking values, and it's interesting to me that, on any nightly news show, you can have demonstrations of individuals from any of the major political parties and/or any other mainstream thought group talking about values, and yet meaning very different things.

So I think one of the challenges to the values group of the Forum is to try and get some sense first of all of what is meant by "value," and what is the formal link between values and public policy. That is, what is the formal link between what we say is important to us, and how we make our choices. And I will remind you of one of the first objectives of our activity, and that is to identify values presently important to Canadians and to identify their implications for public policy.

So I want you to understand that those of us on this committee, while we've had a hard time in grappling with what this is, and everyone who knows that we have a values committee of the Forum says isn't that wonderful, you're paying attention to values. But as we try to translate that into what does it really and specifically mean, we have a major challenge.

Let me then just give you a few thoughts as to what we've learned about what values are, and then I'll show you the kinds of activities in which we're engaged, so you'll see how we're trying to make the link. What is it that we say, and how is it that we choose? If I can use a common expression, do we put our money where our mouth is – do we in fact make what we say is important, important in our choices. That is the practical question – and I remind those of you who don't know anything about ethics, that ethics is not theoretical. It is the discipline that deals with choice when the choice is value laden, so our object is to be helpful and informative, not only to the other working groups in showing the values background implications, support and obstructions, but also to do that with a recommendation to the Forum.

So first, the definition that we are more or less using as operative is that a value is an enduring belief that provides a guide for action and choice. We don't have time this morning to go into each of those, but each of those matters. It's a belief, it's not amenable to factual information alone as a

mechanism of change. It is enduring, that is, not unchangeable, but it is an opinion and attitude. It's not walking down Main Street and asking five folks what they feel today about situation X, decision B, or closure of hospital A. So in fact it's enduring, but it guides action and that's the part about which we're most concerned.

We have attempted to research what we know about Canadian values, what we know about what Canadians say is important to them as a society, and how do those things matter when we talk about the health care system?

You already heard last evening that the health care system, more than any other social structure, in some way embodies important Canadian values. Structures always embody values, implicitly or explicitly. The health care system has been appealing to Canadians because it has manifested two characteristics that Canadians either believe of themselves or want to believe of themselves. And that distinction is one that is worthy of a lot of discussion.

The two characteristics are "fair" and "compassionate." Or fair and concerned for the vulnerable. As we try to pursue this, and before I list our specific projects, I want you to see the dilemma that we are in, where any input from you might be helpful to us. If we take fair, and Canadians really do self-define as "fair," again whether we really believe we're fair, or want to believe we're fair, is an issue.

But, if we set it as a goal or standard, our decisions should be fair, our policies should be fair, our structures and organizations should be fair, now the question is, what do we mean by "fair." Because there are many different definitions. Our concern in values and values discussions is that we throw out the word and we never go to the next level of looking at the different ways in which we might understand "fair." And then we come to a practical decision or policy and are angry with each other for not being "fair" when we have had a different definition of fairness. Those are the challenges that underlie our work and have a profound implication for policy.

So we had an opinion poll and are summarizing what we know about Canadian values, and we have focus group activity right now. We are taking particular values and applying them specifically to choices in health care with focus groups of ordinary Canadians across the country. We are making ordinary Canadians take concepts like compassion and concern for the vulnerable, and apply them to specific choices that individuals, health care professionals, regional health board and institutions make.

We're also reviewing the possibility of a recommendation for a national ethics advisory board, a recommendation that was lost after the law reform commission recommendation and perhaps one that needs to be revitalized. Finally we will attempt to synthesize everything that we know about values, Canadian values, have we changed as a society, and what might all of this mean in terms of unpacking the values in the *Canada Health Act*. Perhaps we'll be suggesting that some values need to be examined again with a revitalized understanding. It's tough work but we think that its essential to the rest of the activity.

STRIKING A BALANCE - TOM NOSEWORTHY

There's a huge distance from the bedside caring for an ICU patient with self-inflicted poisoning, an overdose, and the contemplation of rebalancing health and the health care system, but I am enjoying being involved with the spectrum of interests. When the Forum met first, about 18 months ago, one of the dominant themes which emerged during our discussions was the need to address the issue of rebalancing, and the balance of resources both within the health care system and between the health care system and other areas of public policy.

The working group on striking a balance was to examine where, how, and how much rebalancing needs to occur in order to maximize health outcomes. We're seeking your views during this conference on many of the fundamental questions we have asked ourselves. There are thousands of such questions: for instance, does moving towards a model of population health mean that we should be considering significant reallocation between the health care system and health; what is the appropriate balance between prevention and cure in our health system; and what steps can be taken to make further progress on this front? What should be the role of public and private financing, and how should we determine which services are publicly funded? What mechanisms are necessary at the national level to maintain the right public/private mix? Would we get better value for our health dollars if our publicly funded system were structured in a way that fosters more competition between providers? What forces underlie the growing importance of pharmaceuticals in our health system, and how do we achieve an appropriate balance of resources and accountability in this area? A few questions, but there are thousands just like them.

There are no easy answers to these questions, and I would like to underline that we are very keen to receive your input. You are the key decision makers in health and health care, and we value anything that you have to say on these topics. We've attempted to embody some of these issues in the questions that we're asking today. Complimenting our own work, our research, is the input that we will get from the public and you. We will hopefully accomplish many things in the balance group, but here are six things that we're currently working on:

First of all, the international comparisons area. We've taken a close look at expenditures and health status patterns across OECD countries to make comparisons with other countries. Every time we do this, we stop and wonder are we comparing apples and apples, or apples and oranges, on the denominator issue of the population covered, the GDP and so on. Do we have the correct comparisons on health status, hospital utilization, and so on.

We've developed a discussion paper on public and private financing which I'm sure many of you have seen, and we're in the process of finalizing an analytic piece at this point which will look in much more detail at the public private mix and will assess options for determining the scope of public coverage.

If privately financed models are going to develop in this country, could we please let it happen after substantial thought, debate and deliberation rather than an accident that seems to happen in the

middle of the night? There's lots of room for thinking about private developments in health care, but let's do it after deliberation. We've developed a paper which will look at emerging models of health service organizations in Canada and abroad, and we're trying to develop our thoughts on vertical integration models. We've provided advice on federal–provincial transfers, the cash flow at CST, and so on. We're also working jointly with the evidence-based decision making group chaired by Karen which is dealing with a substantial number of issues associated with pharmaceuticals.

And, finally, we intend to delve further into the question of how best to balance prevention and cure in our health system. We're contemplating the possibility of an expert workshop in the near future. We realize that a great deal of health reform activity has already taken place in this country, and there has already been significant rebalancing. I know that you, the key decision makers in health and health care, spend your energies working on the re-balancing process. We are trying to take a long term view of this, and help with some of the work that you may in fact already be doing.

But we all know that rebalancing is a difficult undertaking at the best of times, because incomes, jobs and institutions are usually at stake. For those among you that will be participating in the sessions today relating to these topics, can I urge and encourage you to think about them from the point of view of broad good public policy? Engage in the discussions today with the thought in mind of what would be best for the Canadian people, and then secondarily for a solution-oriented individual or organizational perspective, because ultimately we will all need to work together if we are going to strike the right balance.

EVIDENCE-BASED DECISION MAKING - KAREN GAINER

The evidence-based decision making group is where all the lawyers in the group migrated. And the problem is, as a courtroom lawyer I am used to dealing with evidence trying to predict past events. When you get into evidence in terms of health decisions, of course you are looking for evidence to predict future events, and its quite a different perspective.

The goal of our working group is to examine how we can bring.evidential standards into the decision-making process and change the culture in which health decisions are made. We are interested in finding ways to ensure that health decisions and decisions both about health and health care are based on the best available evidence. We see this as being important at all levels of decision making, from providers to patients to managers and policy makers.

Our working definition, is that evidence-based decision making is the systematic application of evidence to the evaluation of options in decision making in clinical, management and policy settings. I should add that is our preliminary definition, and part of our work now is to try to put some more flesh on it.

This is not to suggest that there is no evidential base for the health and health care systems now with respect to evidence. Clearly, that would be false. However, we are all aware of examples where good evidence exists about a particular procedure which has not been reflected in practice. And we are all aware of continuing practices which are not necessarily justified on the basis of the best available evidence.

The issue is why this good evidence is not acted upon? What are the barriers that prevent the implementation of changes based on the evidence? There are a number of barriers which come in many different forms and structures. We are interested in identifying these barriers and trying to remove them. One of the predominant barriers to change is the accessibility of information. Is the evidence in a form that is understandable and accessible?

There are other issues that we need to be investigating. For example: Are the current incentives in the system an impediment? What about the other interests within the system? One can only imagine how different the debate on hospital downsizing or closures would be if evidence were the only issue on the table. We also need to keep in mind that evidence consists of more than just randomly controlled trials. There are many kinds of evidence which shape decisions; some social, some political, some predominantly fiscal.

As a starting point, we came to our work with the strong belief that the key ingredients are in place to make a better health care system for Canadians. We have a good research base in Canada and there is a lot of evidence as to what works and what doesn't work. What we need to do, is change our policies so that this knowledge is used properly in making our health choices. The working group is here to solicit your views on a number of issues that we have been grappling with over the last year.

We've been told that we need to strengthen the role of evidence-based decision making. This raises the question: If the health system of the future had a well developed culture of evidence-based decision making, how would it differ from what we have today?

There are fundamental questions which need to be addressed. For example: what constitutes evidence? How will we know when to change practices? Still another question is: Are the standards of evidence themselves variable depending on the culture or the view of health in which one operates? In terms of creating an evidence-based decision-making system, what infrastructure is needed? What health information infrastructure is needed to support evidence-based decision making in Canada? And, how do we get there from here?

What kind of tools and information do we need to put in place to improve decision making by providers, patients and policy makers? These are certainly not easy questions to answer and we look forward to hearing your views. Your input will complement our own research which we have commissioned to assist in developing more specific policy proposals.

And in addition to seeking inputs from professionals like yourselves in the field, we are also seeking the input of Canadians through discussions groups and the several thousand workbooks that the Forum has circulated. Just briefly, the research that our group has commissioned includes examining the concepts of evidence and evidence-based decision making, identifying cases of successful implementation of evidence-based decision making, and cases illustrating opportunities for improvement.

We are also examining the health information infrastructure needed to better support evidence-based decision making. Examining decision support tools which apply information technology to support more effective health care decision making. Identifying strategies for broadening the role of Canadians in decision making in health and health care.

There has been a great deal of work on evidence-based decision making across the country. We hope to build on this work. I believe our challenge is to change our culture of decision making so health decisions are made on the basis of good evidence. We should not be basing health decisions solely on the need to balance budgets without thinking of the long term consequences to the health of all Canadians. If we want to avoid arbitrary decisions, we need to move forward with an evidence-based decision making model.

To do our work we need your input. I look forward to listening to your ideas. I can assure you that your assistance will play an important role in the work that we have to do.

SEEKING SOLUTIONS TO HEALTH - LOUISE NADEAU

The main question we need to answer has to do with the distinction between health and the health care delivery system. Clearly, the National Forum on Health's prime focus is health. Our goal is to improve the health of Canadians.

At the start, Richard Lessard described our goal as having good cars, and not necessarily good garages. That has remained our focus. At the same time, it has become clear – and Marc Renaud hit the nail on the head – that a major factor in health has to do with how we live our lives, how we deal with overpowering events (job loss, for instance), how we resolve long-term problems like dealing with a handicapped child, or chronic illness, or poverty. And society's response becomes a factor, as well.

Is our society supportive? Or does it take on a threatening face, in effect making things more difficult? How we were brought up – this whole question of childhood development – is clearly more important than the health care delivery system. And it's the question that underlies the work that we do.

When we asked Canadians across the country how they felt about health and health care, we documented their responses. I'd like to share some of them with you. When we talk about factors that influence health, it's clear that we are in fact looking at a combination of factors. At the top of the list is income. But there are other factors, as well: the environment, heredity, and education. Essentially, we recognize that there is a causal link between income and health.

We've come to realize that the higher an individual's income, the longer that individual's life; the poorer one is, the shorter one's life. In some countries where the disparity is less evident, there is less of a discrepancy between rich and poor. That said, the discrepancy is evident in Canada, and it's clear that we would all benefit if it were minimized.

Looking at Canadian data, it becomes clear that the higher the household income, the higher the level of education, the more importance is placed on health. On the other hand, poorer Canadians place less emphasis on health. And there's a link between longevity and the value placed on health. We've come to realize that most OECD countries don't spend quite as much on health. The U.S. spends 14 percent of its GDP on health; Canada is second, followed by France, Germany, Sweden, Japan and the U.K. When we look at life expectancy, there does not appear to be a link between monies spent on health care and longevity. The country not to emulate is, of course, the U.S., where life expectancy is lower, and the infant mortality rate is higher. Canada is not doing quite as well as Japan and Sweden (where they spend less on health care), but comparable to the U.K. and France. It's clear that the amount invested in health per capita in Canada and other OECD countries does not guarantee a level of health.

In the 70s, the theory was that the more you spent on health, the healthier the population would be; it's a theory that hasn't been validated. We know that, between 1975 and 1995, health care costs

went up significantly, particularly for drugs, and Minister Dingwall alluded to this yesterday. (In 1975, drugs accounted for 8.9 percent; it's now 15.1 percent.) In 1993-94, health care accounted for a significant portion of the national budget, at 13.1 percent. We at the Forum, together with Canadians, will have to tackle this issue in coming years.

I haven't spoken about children. When we look at poverty, we realize that we're not doing very well. In fact, childhood poverty is on the upswing. Now, we've seen how important it is to provide good care from birth to the age of three, so that a child entering school at the age of five will have the ability to concentrate, the self-control to interact with peers, and the cognitive ability to learn. Children who stay in school, who learn how to read, will grow up to be healthier adults.

We consulted Canadians. What did we learn? Generally, Canadians are well aware that they have to work to achieve good health. They realize the importance of education, and of a healthy community. They know that we are each responsible for our own health, that our lifestyle choices are important, and that we must access health care services responsibly. However, when we look at what concerns Canadians, we get a different picture. We are preoccupied with illness, and the effect of illness on loved ones. We are concerned about the health care system, and the lack of uniformity in the changes that are taken place in Canada. We are very much afraid of losing our health care system.

Tom Noseworthy said it: Canadians are afraid there'll be an accident one night. And they're going to wake up the next morning and find they no longer have a health care system. What's more, they won't have seen it disappear. Finally, and Nuala was clear on this, it's hard to make choices, but at the same time it is necessary to make those choices.

There's a paradox here. Individuals are concerned about health. Understandably, they want a solid health care delivery system that will be there for them, that will take care of them. When you appeal to their reason, they focus on the common good; they're looking for policies that favour hard work, education, family and children. And therein lies the paradox. The only way we will be able to make changes is if we face, and overcome, our fears. We must ask ourselves who, in the health care system in Canada, would benefit from fueling the fear of Canadians in this regard. Who stands to benefit by fomenting the idea that hospital closings, for example, are a threat to health care delivery? Certainly, those are questions we'll have to answer.

I'd like to close by asking a few questions. First, the one that Marc Renaud asked: So what? What do we do? How do we get beyond the theories? How do we find the black cat in the darkened room?

Second, we need national policies to see us through the next millenia, policies based on the big picture. At the same time, what has become clear as a result of our work, and from all the position papers we've received, is that any collective action must take into account the common good. The one-size-fits-all approach won't work. The Canadians we consulted told us that, in their experience, federal policies aren't flexible enough to meet community needs. At the same time, there's the whole

question of accountability for public funds. We need criteria, and they're not easy to set in a democratic system based on accountability.

And what about intersectorial cooperation? How do we ensure that health, education, communication and law enforcement professionals work together? One of the position papers we received outlined a fact found particularly distressing. A sexually abused child, say aged between five and ten, is traumatized when he reveals the abuse. That's when the legal system takes over, and health care professionals can no longer do their job. This doesn't happen everywhere, of course, but it does happen. The very fact that it happens underscores the need to bring all services into line.

In the field of alcoholism and drug abuse, my specialty, law enforcement and the courts have had to work in unison to develop effective prevention policies. Issues of intersectoral responsibility are not always addressed at the implementation stage, and that's a challenge we face. On the other hand, it's clear that we have to change how we finance health care so as to take into account the potential of a service or drug to improve the health of Canadians. Budgets have to reflect this. Again, there's a lot of work to be done. Tom Noseworthy alluded to the question – evident in the data – of overprescribing drugs.

The information we've amassed leads us to think that the model we're looking at will probably be a multivariate one. We have to take into account what patients and physicians expect, how we view physicians, and the whole question of pharmaceutical trusts. How are we going to solve this costly problem that touches on funding, practice, expectations and the doctor-patient relationship?

What about prevention? To what extent are we going to demand evidence of the effectiveness of prevention before funding such programs? These questions are particularly thorny because medicine is an evidence-based science. There is little evidence to sustain preventive actions. It's virtually impossible to demonstrate their effectiveness. At the same time, we know prevention is the answer, that we must establish criteria. Often, funding is denied based on invalid or inconclusive research.

Two other factors come into play, and they have to do with the psycho-social aspects of health. These are factors linked to poverty, education, and the effect of infrastructures on individuals. Passivity, the inability to resolve problems, poor self-esteem, a feeling of being disenfranchised – that's how poverty attacks a person. And health care professionals must take these factors into acccount when they diagnose an illness and prescribe treatment.

Let me close by saying that one of the greatest challenges we face is to overcome the irrational fear that is currently immobilizing Canadians, to embrace a broader, more reasonable perspective. Because such a perspective is likely to be healthier and more productive in the long run. Emotions will only gnaw at the empowerment we must all embrace in our search for a longer, healthier life.

SEEKING SOLUTIONS TO HEALTH CARE - NUALA KENNY

I'm actually anxious that the comments I make about health care are helpful, because the suggestions and advice that you will give to us as a Forum and that we, as a Forum, will provide to the Prime Minister and the people of Canada about health and health care are important.

In almost every one of the small discussion groups, we have discussed whether we're dealing with health or with health care. In fact, we're dealing with both. We're attempting, at the level of the Forum – all 24 volunteers, with our wide perspectives, and with the help of our staff – to develop a vision for Canada and the health of this country for the year 2000 and beyond. So it is a larger vision, but how we get to that and how we ensure that the parts that work in our present system are not dismantled as we move to a larger, broader vision becomes a serious question.

I'd like to very briefly summarize why I think we are where we are with health care; then I'll outline some of the challenges that are the day-in day-out experience of those of us who work in health care. They will be identifiable to those of you who are within the system and also to many of you who have been patients or family members of patients, as well. Then, some very generic questions that I think underlie the discussion that each of you will participate in and where we need advice.

Let me first say something personal. I am a physician, and for eight years in Nova Scotia and for three years before that at Queen's in Kingston, Ontario, I have held positions as joint chief of pediatrics and university department head. I worked for 11 years as chief of pediatrics, eight of them in a children's hospital during a period of increasing fiscal constraint. The year I became chief of the children's hospital in Halifax was the year the hospital first initiated a deficit reduction program. That had never happened before.

My first board meeting as chief of pediatrics at the IWK was addressing the issue of 'no deficit.' That had never happened to my predecessor, who had an idea one day, started it up the next day, and three weeks later convinced the government to give him money for it – or so it seemed. As a pediatrician who has been in the health care system as a chief of service at a tertiary care hospital serving the complex and serious health care needs of children in the Maritimes, I am committed to children and families, and I feel very strongly about health care.

On the other hand, I am committed to the health of Canadians and to the vision that the Forum is attempting to put forward. I believe that committing to both is possible. The questions and the challenges are how to fit different "goods" together. And that is the challenge of most ethical reflection – it's hardly ever a choice of an evident good and an evident evil, though we do sometimes have those clashes. Almost always, we are grappling with two or four or ten things that are "good" and trying to extract the most good. That is our challenge today.

I have grappled with downsizing and change in a situation where I've also felt an enormous personal responsibility for the quality of care for the sickest and most needy – children who are ill in our society.

My Mom used to say, "it takes two to make a fight," and her incredibly wise Irish Catholic wisdom holds true today. There is no difference of opinion where there is not truth and fault on both sides.

I beg of you, as we grapple with what is the proper place of health care in this vision of health for the future, to try to maintain a respectful understanding that there are a number of "goods" from a number of perspectives, from a huge range of committed and caring people. They are all grappling with the same question, maybe with a different history, or a different vested interest; or with a different education or historical advantage in power. But in these days of rapid change, everybody is scared. And in that fear, you don't necessarily see the best of any of us. So it would be helpful if we could understand some of that problem with change in our reflections.

Now, the history of Medicare in three minutes. It is very important to situate ourselves historically. That is true for all issues, whether they are ethical, medical, personal, religious, etc. Remember where we've just come from, because we have a tendency to think where we just came from is where we've always come from. We think the history of the last 30 to 50 years is the history of medicine. Or the history of health care. Or the history of medicine and health care in Canada.

It isn't so, but it's our history, and we come with a very particular perspective. The characteristics of the health care system under which we have lived and functioned and cared for patients in the last 30 years has been: the federal government gives money to the provinces, and the provinces kick in money with a provincially organized and coordinated health care system. So it's from the feds to the provinces, who run the show.

Then, money is paid to doctors for doctor-delivered health care, and for all care provided as hospital-based care. Move away from doctor/hospital-based care and even though health care was provided, it was not paid for in the same way. Everything in hospitals is covered – drugs, nursing care, physio, nutrition. Moved out of the hospital, the doctor was still covered but everything else now falls apart.

There are two realities here. First is the natural consequence of that direction: the system used what it had – it was a reinforcement. Doctors didn't force this on the public; the public didn't demand it of doctors. Both of those things happened. We together made the situation one of constant orientation towards medicalization, professionalization and institutionalization of our health needs.

With the promises that were made as the *Canada Health Act* unfolded, the timing is important in terms of medical science and technology because in the last 30 to 40 years – and I discuss this frequently as the essence of ethical reflection in our time – medical science and technology changed enormously.

Do you understand that we have changed the nature of medical science in our lifetime? In our lifetime, for instance, we have changed the definition of "dead."

If I go back, not to my good Irish mother, but to my good Irish grandmother, and if she knew that I gave a three-hour seminar on the definition of "dead," she would wonder what in the name of God I am doing with my time. Dead! Talk about a given! How could there be any debate? And yet the nature of human science and technology is so powerful that what was "dead" in every culture at any time throughout all recorded human history is not "dead" any more. Do you understand, using that one paradigmatic example, how profound the influence of modern science and technology is on us?

Consider the period of our recent history (which is the only history we really know in that sense), the enormous advances in sciences and technology in our time, and come together to where we have been. Where have we been? We have been with people expecting new machines - new medication - new cures daily, to the point that when parents bring their child to me or my staff, they expect and demand a cure. "Cure" has never been in the literature in terms of medical commitment or obligation. The language is of our time. Put that expectation together with the incredibly rising cost of this wonderful science and technology, and inevitably we have conflict.

People now believe in medical science and technology the way that most people used to believe in God. Unquestioned. All pervasive. Medical science and technology will fix everything, completely, without consequence! Now, at the same time, we've got a sideline which I call common sense. The common sense of ordinary folk, in and out of the professions, understanding the limits of science and technology, understanding that human distress can not all be answered by prescriptions and interventions and medical professionals. But the fact is, today we have more than 60 different kinds of registered health care specialties. How to make a baby, how to find a mate, how to raise a child, how to deal with adolescent rebellion, how to deal with grief. They are all medicalized. None of the things I just named is a disease or an illness.

So we need to start by understanding, before I challenge you with some questions about the proper place of health care, that it's not "you did this," "they did that," it's not a 'we' and 'they', it's "we" socio-culturally, experiencing incredible advances in modern science and technology.

I'm proud to be a doctor in the Canadian health care system, proud to be a pediatrician in the hospital where I serve. I'm a good doctor – and our people give great care to the children and families we serve, but we're not perfect. The demands are scary, and the costs have become exorbitant. But as we deal with the vision of health for the future, I know that those of you who are outside the health care sector are anxious lest the inevitable concern about adequate health care overwhelms people's ability to see the larger vision.

The concern of those of us who are in health care, particularly physicians, is that in your concern for the larger vision you still demand the same quality of care within the health care system, and yet constantly we have less resources available to us. The reality is that we are in this together. The fundamental question is: "What do you believe is the proper place of health care in the continuum of

health as we attempt to look at this larger vision?" It's not 'health' or 'health care'; it's the proper place of health care within health, and within that, we have a question about the proper perspective within health care. The fundamental questions we are addressing are:

First, what is the proper place for professionally delivered health care in the continuum of health, and do you think that even within health care, we have begun to address the proper continuum which we've always acknowledged? We have health prevention, health promotion, acute care at the primary, secondary, tertiary and now quadrinary level, rehabilitation, palliative care, chronic care, and long term care. Even within health care, we have a focus that has been dominated by technology and science. Why? Because it's wonderful, and has done wonderful things.

So we need to re-look at the continuum within health care, and I suggest that public health has been of concern since the time of Hypocrates, the father of western medicine. There have been public health officials since early Greek times. Somehow we must all grapple with the concept that seems inherently human, that we are more impressed by an intervention or by a shiny machine than anything that is human.

So what is the proper place of health care within the continuum of health? How can we ensure that, as we move to this larger vision for Canadians, we don't destroy the excellent high-quality health care that we have provided in this country? How can we improve it? And, can we deal with the continuum even within health care, in an appropriate way?

Second, can we address whether or not health care needs are unique? We deal with them as if they were unique. Two of the questions that fall out from that general philosophical concern are:

- Are health care needs different from other care needs?
- Why is it that we feel a duty and an obligation to respond as a country to health care needs in a particular way?

The questions underlying this are: What kind of responsibility and accountability for health care do we need? I've heard people, repeatedly, both at the Forum and here, talk about accountability, and surely, it's one of the things that we have not stressed in our experience as we "live out" the principles of the *Canada Health Act*. There's no accountability anywhere there. But my concern in this day of tough times is, do we suddenly relate accountability, without scientific evidence, to everybody who has a disease that might have a lifestyle related cause and say, "It's their own fault"?

Can we worry that, as we make changes, we go from over-medicalizing and over-responding with inappropriate education and inappropriate empowerment for health care, to telling people to assume responsibility because they were supposed to be responsible for their own health care in the first place.

What underlies that? The ignorance that we have about the real relationships between different behaviours and lifestyle and disease? So where is the place for accountability, and does it become punitive with individual care, or is health care need somehow different?

What is appropriate medical care? If we attempt to look at medically necessary or essential services, we can define them any way we want. We can make 'medically necessary' nothing but "life threatening," or even "life threatening in the next 24 hours." We can define it as narrowly or as broadly as we want. We need to deal with that question, but my question to you is, "In what way is "medically necessary" as opposed to "health necessity" to be defined?"

Let me ask some questions about what is good medical care. What is it? It's beneficial, meaning it's for the patient's human good. It makes no difference that I've changed your liver enzymes if I haven't alleviated your suffering or in some way advantaged you as a human. That's the fundamental question of modern ethical reflection. But the larger human issues are ones we have to deal with together with the public. We have allowed our interaction and communication with the public to be such that their larger concerns about their human and familial good have not been addressed well.

We have a technology – so use it! It might work – so try it! It could be fixed – so fix it! Regardless of the cost or benefit in human terms. The public really does come to believe (and we have done nothing to educate them to the contrary) that if we find the right doctor in the right hospital with the right equipment, any medical concern can be dealt with. More importantly, we have translated not only "chest pain" into a medical concern, but "heartache" too.

We now have children coming to our emergency department because their parents don't know how to deal with ordinary childhood illnesses, because the extended family support of an earlier time is no longer there. We need to understand that we have medicalized and disenfranchised people when we have a profound obligation to deal with their larger health needs and their own responsibility for health in a proper, not punitive way.

Second, in addition to health care intervention being beneficial, it should be effective. All of the evidence-based discussion is dealing with that in depth. It is paradoxical that much human medical intervention has no proof of any kind. Now, that shouldn't be a surprise. Medicine is only partly science. But the questions that fall out from this are very serious. What is the place of scientifically-proven evidence over rampant individual demand and choice? Can you demand that the system should pay for an alternative treatment having no scientific proof? Or can you insist that you receive an experimental treatment that has not been proven? How do we link the demands of scientific medicine with a personal demand for choice that is driven not by scientific concerns, but by personal values?

I suggest that "beneficial medicine" means that it is more than scientific intervention: it relates to issues around persons and their lives, and the proper use of medical science and technology in their suffering. "Effective" means that in fact we have to get better at this.

Within the profession of medicine and within health care itself, we are not yet good with peer review. Even though it's a primary right and privilege of the profession, we still don't do it well. The danger is, as we move through changes in health care systems, as people demand or impose certain

kinds of standards, we run the risk of interfering with that human dynamic which is the doctor-patient relationship, the nurse-patient relationship, or the caregiver-patient relationship. Science has its place, but it is always brought to the bedside by individual human beings. So much of what we practice is of no known value; we deal with these variations with idiosyncratic practices that have no real basis.

Finally, our interaction and discussion with the public about the limits of appropriately-used medicine, is really very poor. When we talk about the money that's put into the end of life, we have built up a system where people, for themselves, or more importantly for loved ones, think they must do everything – whatever "everything" is. The purpose of medical science and technology is to help humans. There is no benefit in medical science and technology if it does not advance the cause of human good. So while that dialogue might bring comfort, in a society that has come to believe in science, it's hard to talk about other kinds of understandings of the "good."

The bottom line question is: "What are the issues that we have to contend with, across the concerns of health and health care, that ensure we have a broader vision of health but at the same time don't destabilize the health care system so that particular experience of human need which is illness and vulnerability is disabled? We can address the larger questions of health because we've done health care well. Let's ensure that we don't create a situation where we abandon areas where we can do good because of discussion based on jargon and rhetoric.

The final fundamental question about the challenges to the practice of good medical care within the Canadian health system will continue to be the proper uses of science and technology for individual human good. How do we balance the enduring question of justice relative to the extreme health care needs of the few against the health needs of the many? Canada must understand both things are "good" but, as we make policy choices, we have to take into account and limit both. Your help would be appreciated.

FUTURE TRENDS AND ISSUES - LYNN SMITH

This morning, we are going to try to bring together the work of the various discussion groups from yesterday, and I've been asked to begin with this synthesis focusing on future directions. So, using the summaries that the conference secretariat elves prepared, I've tried to bring out from what emerged yesterday in the group discussions, and in the plenary, what you think the future holds and what you would like the future to hold.

Now, what evidence do I have for this? That takes me down a brief side road. As Karen Gainer said yesterday, the lawyers on the Forum have tended to gravitate to the evidence-based decision making group because we think we know something about the concept of evidence, and there are kinds of evidence, illustrated by this little story: There was a jury trial in which a man – we'll call him B.J. Simcoe – was charged with murder. Simcoe was charged with murder because there was strong circumstantial evidence that he had killed Charlie Brown, but there were no eye-witnesses and the body had never been found.

In his address to the jury, the lawyer for the defence decided to be a bit dramatic. He tried a little device to see what happens. After he had given the jury a full and glowing description of the importance of the presumption of innocence and of proof beyond a reasonable doubt, and after emphasizing at considerable length the fact that although Charlie Brown had not been seen for five years and there was all this other evidence, his body had never been found. He wound up by lowering his voice to a thrilling pitch. Whirling, and pointing at the door at the back of the court room he exclaimed, "Ladies and gentlemen of the jury, as far as you know Charlie Brown is still alive and is going to walk through that door." And he then paused and said, "Ladies and gentlemen of the jury, you have a reasonable doubt because you all looked."

But there's more. Because do you know what happened? The jury went out and it was back within half an hour, and its verdict was guilty. Now, in Canada, you are not supposed to ask a jury afterwards why they did what they did, but just suppose that happened, somehow. And when the foreman was asked, Why did the jury convict? he said, "Well, we all looked at the door, but B.J. Simcoe didn't.

So, there are different forms of evidence. There may be evidence of something from the fact the dog didn't bark and, in some ways, I'm drawing inferences about your vision and your prediction of the future from some things that weren't said yesterday.

I've tried to draw some assumptions, some expectations, on what the future holds, from the work groups and plenaries. Perhaps I should say, on what we'd like the future to hold for us. I ask you to give a lot of thought to these assumptions.

Do you see the trends I am outlining taking shape? Are they inevitable? Or can we intervene to change their course? More particularly, can the government change their course? In your view, on

which issues should the National Forum on Health concentrate its recommendations? And what should those recommendations be?

I've asked myself, what does this group of highly knowledgeable and committed people seem to predict that the future holds, and what does this group seem to want the future to bring? What is its vision? Here are some features explicit and implicit in yesterday's discussions.

There will be a *Canada Health Act* with its five principles, supported by the two values that Nuala Kenny pointed out Canadians either hold, or think Canadians ought to hold, namely fairness and compassion.

Policy formation will be, or should be, guided by the three goals which emerged from the values discussion groups, shaped overall by the principles of individual responsibility, public participation, and accountability:

- a healthy population
- equality of access for individuals, and
- quality of care.

Now here's a prediction I think is implicit in a number of the discussions: there will be ongoing pressure from south of the border and from Canadian proponents of a mixed system to move toward a mixed or highly privatized system in all areas including physicians' services and hospital care, but there will be resistance to that pressure on the grounds of:

- we're not Americans,
- the global cost of the system,
- the quality of care, on average, and
- our values.

Implicitly in the discussions yesterday, I saw a shared assumption that there will be ongoing fiscal constraints, and the range of that seems to go from an assumption that there'll be no increase in the funding for health, through to the assumption that it will continue to be necessary to find cost savings and efficiencies in the health, social service and education systems.

It's also clear from the discussions that you would like to see the implementation of some of the changes flowing from an emphasis on health instead of health care. This prediction or expectation is reinforced by the high level of public acceptance of this paradigm shift toward an emphasis on health and the political commitment that we are seeing. The Minister's statement on the opening night of this conference, that he is the Minister of Health, not the Minister of Health Care exemplifies this.

Particular examples of the kind of changes that fall under this category include:

- a greater emphasis on public education,
- education of the health care professions to alleviate patterns of paternalism or dependency,
- health information systems that should be created,
- there should be assessment of the impact on health of decisions in other areas, for example decisions about social services, and
- assessment of the impact on other areas and on particular groups of people of decisions about health – for example, taking into account the impact on home-care policies on women, particularly elderly women.

Picking up on one of Nuala Kenny's main points, there seems to be a strong expectation, having said all of the above about health, that in shifting an emphasis to health we will not destroy the health care system in the process. This group assumes, and I didn't hear any dissension from this, that drug prices will continue to rise or will not fall unless there's an intervention.

Referring to the decision-making method, here's an idealistic assumption or wish, that was stated in different ways within various groups. There's an assumption or wish – I'm not going to put it as strongly as a prediction – that decisions about health policy throughout the system of health care will be made rationally, based on evidence with rigorous analysis of the options, with an understanding of the value choices implicit in the decisions. Furthermore, links will be forged between values and public policy, and between evidence and public policy.

To put it another way, there's the hope that health reform by stealth or by accident – or as Tom Noseworthy put it, in the middle of the night, – will not be the method of choice and that health policy driven by regional, federal/provincial or other turf considerations will become unknown. Indeed, an idealistic expectation but one worth mentioning.

I think, as well, implicit in the discussions, there's been an assumption that Canadians will continue in a general way to support the values of pluralism and respect for diversity, for example, with respect to therapies which are accepted in cultures other than western European, such as First Nations peoples and people who have immigrated only recently to Canada. There's a hope and a wish that health care providers and individual citizens will pick up on this and reinforce the habit of rational or evidence-based decision making in policy makers.

Several things lie behind the assumption that we might be moving in this direction, as we certainly should. Ongoing fiscal restraints seem to require it. There's been a vast amount of discussion and public education about health, people are much more aware of the issues not only at an individual level but at a community level, there's been a widespread assimilation of understanding about population health approaches, and there's pervasive public skepticism about top-down processes.

So it seems to follow that there will have to be higher quality, more rational, and more inclusive decision making throughout the health system. However, I think we're all realists and we recognize various barriers to change in the system. I don't think anyone is predicting that these barriers are

automatically going to come down as if a tornado went through them. They are going to continue to require attention and either circumvention, or, I suppose, attack.

What are the barriers? Well, Louise Nadeau talked about fear, the fear that, to put it in one context, in emphasizing health we are going to destroy the health care system; fear on the part of individuals that their particular economic and professional interests are going to be threatened; and the extreme difficulty in making the trade-offs that are necessary when there are important values involved. The values may be reconciled, but we can't have it all. We have to make a choice between one option and another, and it's always hard. People are not ready to make that kind of a decision until they really have to. This group isn't any different, nor were the groups in our public consultations.

Now there are other implicit assumptions in the discussions of course, and I think it should be said that there were assumptions such as that the sun will rise tomorrow and, more importantly, there was an assumption in our discussion that there will not be a dissolution of Canada because of course if we think about that, there would be an all-bets-are-off reallocation of federal/provincial responsibilities and a truly fundamental reassessment of values. That was an implicit assumption in the discussion, whether or not it is accurate.

Going back to the beginning, then, we're asking you this morning to think about whether they really are assumptions, expectations or wishes which you harbour for the future? Could action by government affect the likelihood of them, or are they inevitable? And what is it that you would argue for, if you were a member of the National Forum on Health, and you were trying to come up with a few key recommendations for action by the federal government?

The groups that follow have been re-allocated, so you'll find yourself with a new group of people that will have the benefit of the discussions from yesterday. We're asking you to tell us the most important themes that emerged from these discussions, and to tell us what we missed. What emerging issues weren't captured in the materials or in the discussions yesterday? What new ways of thinking are out there that we haven't seemed to assimilate? Please tell us. Forum members have been listening carefully yesterday and will continue to do so today. The discussions are being captured at the plenary and in the groups. They will be part of the Forum's consideration.

You're also welcome to submit conference briefs. The report of this conference will be sent to all participants as soon as possible afterwards, and we're entering the crucial time when we have to try to synthesize what we've heard and determine the directions in which we want to make some key recommendations by December. The results of our public discussion groups will soon become available. We'll be drawing on those, on the commissioned research, and on this conference as well as on other ways and means that we've had of gathering information.

We'll be discussing strategic directions, and in September or October, there will be some further consultation in a way to be determined because constraints are imposed by the short time frame. We want to avoid the false dichotomies that are often set up, and it's not difficult to suggest a range of them. I can do no better than to reiterate the one that Nuala Kenny stated yesterday: Health or health

care? Yes! The Forum has to do some new thinking. The Forum has to make concrete recommendations that will be do-able, and to make them by December. We're offering you the opportunity to help shape our advice to the government and we're most grateful to you for having accepted that opportunity.

REPORTING BACK FROM WORKSHOP GROUPS

COLIN MCMILLAN

I will give you a brief overview of what I think the main themes and concerns are in relation to our discussions as I interpret them from what I've heard from groups 10, 11 and 12.

The first issue that strikes me is this discussion about health and the health care system. I have found the proceedings very lively, very informative. I have found it very interesting as a physician to have multiple inputs from multiple well-informed observers during the course of the weekend. I have sensed that we all have the feeling that the system as we know it, or as we did know it, is under a lot of pressure, under a lot of scrutiny, and will definitely have to change.

The sense I get, though, is that people still want to proceed with caution. They want a sense of balance, which we've heard about, and they want a systemic rather than a piecemeal approach. In other words, if you're going to address the system, then the answers must be systems approaches based on evidence, research and trials, rather than hit or miss.

People want our system of health and health care delivery to be based on people. And this includes, (this is maybe new to some of us) some attention being paid to the work place in the health care system, and in the private sector. The work place, including the workplace of many of us in the health care system, is a very important component of our health care system and health in general in our community,

The second issue relates to the notions of a combination of information technology and communication systems. Many people feel that we have a lot of data, but we either don't receive it in the appropriate form to keep us informed, or in a way that we can use it. There are many examples of this. One is that it is no longer sufficient, in discussing the broader implications of health care and allocation, to simply use some outdated OECD statistics, or indicators of health, when there are much better data that could or should be available for that sort of discussion.

Some of the other examples: many of the participants want more information from a financial point of view in general, more input to the Forum from people with financial interests and expertise in such areas as:

- the whole area of federal/provincial relations and funding, with the CHST;
- the whole issue surrounding the pharmaceutical industry.

This is obviously an issue of cost. But there must surely be a lot of data that we can receive to discuss this more informatively and more intelligently, because this is a burning issue that is not going away. It has to be addressed. We have to have the facts and the data upon which reasoned discussion and arguments can be based. I've heard a lot of people questioning how health care

providers and physicians are paid. There is a lot of open discussion about the fee-for-service concept, its pluses and minuses, and a lot of work has to be done on the notion of capitalization. There is also discussion on the topic of primary care health models, specifically multiple points of entry into the primary health care system using several providers cooperatively.

Another subject that I think many of us can relate to, is a concern that we don't really have good facts or good data about beyond-funded, or underfunded, areas of the heath care system. I've heard very passionate appropriate comments about the general idea of shifting health care from an institutional to a community base. This, at a time when perhaps the community isn't ready that quickly to undertake those responsibilities. Home care is but one example. I've heard some concern that perhaps this is an area the private sector is looking at very seriously, and what will be the potential implications of that? We need more data.

Finally, I'm going to raise a paradox, for your discussion and deliberation, that I think the Forum may have to resolve: consistently, I've heard people say they are in favor of the *Canada Health Act* principles and that they favour national standards and principles. The area they wanted to discuss is comprehensiveness. What will the system cover? Should we define, as we do not do now, what is medically necessary, or should we change that term and broaden it in other areas? In the end, people feel that if the Canada *Health Act* is to be re-visited, if that is possible, then the area of comprehensiveness – what is covered, and how it's covered – should be examined and discussed and brought in to the public forum.

On the other hand, I have heard consistently, many people say they also favour regionalization, decentralization, local autonomy and needs-based services. I don't quite have in my own mind, the ability to marry the idea of a strong federal system with a redefined *Canada Health Act* that has enforceable standards, and matching that with the ability to devolve into a reasonable provincial economy base. I suggest to you, very strongly, that perhaps the biggest challenge to Dr. Noseworthy and the balance working group is not funding, not this rhetorical emotional argument about private and public funding, but a resolution of the appropriate balance between what we want nationally, regionally, territorially and in the local autonomy. I suggest that that's the big challenge to the balance group.

In conclusion, as a practitioner and a physician, the biggest concern that I have is that the Forum will listen to us and come up with recommendations that are meaningful, workable and do-able. I'm sure there aren't many of you in this room today, who don't comprehend that we on a day-to-day basis perceive that we work in a highly unpredictable, destablized, unstable situation where things are happening very rapidly. Its very difficult to respond to these things at a time when the demands on services have never been higher – when reasonable public expectations have never been higher, and yet the resources to deliver all aspects of care are under great strain. Without major reconstruction, many of us are concerned about the ability of the system to do this and still assure quality.

Those of us who are physicians and health care providers, wish the Forum well. We wish them insight, wisdom, determination and independence.

LIL SELBY

The three groups which I was privileged to attend came up with these basic themes:

- accountability
- accessibility
- the moving forward from health care to health, and
- the coordination of services to a single point of entry.

They unfortunately did not progress to all of them, so we don't have their thoughts on the last two. However, there are a number of common themes, that come through from all three groups. And there are strong feelings that :

- there should be an evaluation of all health policy initiatives so that the health goals are met in an efficient manner, and resources are used wisely and well.

- we should base what we do on information, not guess work.

- there should be strong national standards under the *Canada Health Act*. We need now and will continue to need a strong federal presence in the field of health and health care.

- there needs to be stability in the funding for health. They suggested that we return to the level of funding that was available in 1993.

Another major concern is the cost and lack of availability of good information on which to base health decisions. It's cheaper and easier to get data from the U.S. than it is from our own sources of information. Somehow, this has to stop. We have to share data across Canada, from all provinces and territories. With the current technology, there's no reason why we shouldn't, except that we haven't got ourselves organized yet.

There needs to be a vision of what our health and health care system should look like, beyond the term of any federal, provincial or municipal government. It simply is not good enough, to continue on the path that we have been on for many years. Where the current government makes decisions that can be enacted during their term in office. Then the next government takes over and makes other decisions. That simply is not good enough for the Canada that is going into the 21st century.

We are also interested in good research and the need to broaden research into health and health care. There has to be more research in the whole field of service and service delivery. There has been no serious attempt to analyze the effects of regionalization and downsizing. What is this doing to us and to our health system? We need to learn from what we've done, look at our mistakes, and avoid repetition.. We'll do better in the future.

We need to recognize the fact that there are highly specialized services that need to be provided beyond regional boundaries, beyond provincial boundaries. That we have highly specialized needs.

One of the areas is AIDS. Across Canada, we need to share the information that we have regarding prevention, control and treatment of HIV and AIDS. Regionalization results in a smaller population base that will not support the necessary modernization of our techniques in these areas. We must always ensure that the directions taken by governments in Canada reflect the Canadian values and the care and compassion Canadians always express.

We also need to put the necessary testing in place to evaluate the effects of changes. What effects do these changes have on people? This is not just changes in funding or delivery of health care. The determinants of health tell us that there are a whole lot of other elements that affect the health of Canadians: income security, levels of education, the provision of employment. All of these affect our health and particularly our mental health. It's essential that the future health care system be accessible to all Canadians. Our groups all felt that the shift from health care to health must go forward, that education of the public must proceed at all levels, and the schools have a big role to play in this.

With apologies to my fellow teachers, knowing how overwhelmed they already are, I believe that public schools and universities have a role to play in making Canadians more responsible for our own health and well-being. And we can do it.

That basically sums up the ideas that came from the three groups.

I want to put on my other hat and talk to you briefly about the needs of the people I care about, who suffer from a mental illness. We have been, and continue to be, the orphans of the health system in Canada. And the orphans of the welfare system and the employment system. It's very difficult to maintain any level of care provision for people with a mental illness in a time of chaos such as we are currently experiencing. We need desperately to have good access to the services that our people need. Services for people with mental illnesses are being stretched beyond the limit.

I belong to a voluntary organization. We beg for your money on a regular basis so that we can try to provide services for people with mental illnesses. Somehow, they don't fit into the picture of Canada as it currently exists. We desperately need more early intervention. We have children in our schools, who are not recognized as needing help for their emerging mental difficulties because we don't have the time or the money or the expertise to do so. We also need to take a long look at the effects that cultural diversity is having in the field of mental health.

I come from British Columbia, where we have a tremendous influx of people from other countries. We have had huge influxes from the Indian subcontinent and are now receiving thousands of new citizens coming in from elsewhere in Asia. We see people who have different attitudes towards what public systems offer, and find it extremely difficult to reach out and let these people know what is available. Health care in Canada needs to examine the provision of services across diverse cultures. For us, funding is always a problem.

In regionalization, we've lost. We have no place at the table. We are allowed to be represented, only by putting ideas forward to people who sit on regional health boards. We're not sure how we get back to the table. But if we take into account the fact that the determinants of health for everyone apply doubly to people with mental illness we must try to think pro-actively about how to help include, rather than exclude, these people.

I am a supporter of deinstitutionalization, but you cannot take people away from the security of the institution, if you do not have in place the community support systems that they need in terms of housing, in terms of community clinics, and social service supports. Instead, we have the homeless on the streets. It's not a pretty picture for a country with a reputation as one of the best places to live in the world. I want all of you to go home and think about one of the disenfranchised groups that we care about.

DR. RENALDO BATTISTA

This was really a very rich experience for me to be here this weekend. It ended up being a very intense work experience.

I will start by briefly summarizing some of the key points I've heard in the three groups for which I was responsible. I'm not really trying to be exhaustive in my remarks, but will try to focus on some of the issues that seemed to be recurring often.

Health reform should not be financially driven. Or perhaps, the better way to interpret this would be to say that although the fiscal constraints are the initial driving force behind fiscal reform, we have to be realistic. People feel strongly that health care reform should proceed as much as possible on evidence, and not driven only by cost considerations.

People feel strongly that the *Canada Health Act* should be reinforced. But, at the same time, they think that this is a time for redesigning or reinterpreting the basic principles of the *Health Act*. And I must confess that consensus breaks down completely on the interpretation of the principles. There is no consensus at this point in time as to whether, for instance, the principle of comprehensive health care or universal access should be revisited or expanded so as to make some space for a private sector in our health care system. There is a wide spectrum of opinion on this very critical, but difficult, issue.

The second key issue, which is related, is the distinction between health and health care and the complimentary nature of these concepts. In this country, we've been extremely productive in recent years producing documents and conceptualizing things. But, the real issue is operational. We need to come up with an operational definition of health and health care.

People felt strongly, that Canadians want to have terms of reference, or a conceptual framework, for the system of health care. Nationally and in each province, people feel strongly that consumers

really want to be part of the decision making process at the local level. I insist on these two elements: people want to be involved in the decision process at the local level, but at the same time, they don't want to function in a void. They want to have some sort of direction. This is where I believe the ministers of health, the Prime Minister himself, the Forum and the ministries, all have an important role to play.

With respect to new thinking, a couple of ideas were floated. I don't fully agree with them all, personally, but will present each one. The first one was that some people felt that, in order to enhance this health system, we could create some sort of incentive within the system, as some sort of merit, of reward for good health.

Another issue was the reaffirmation of the importance of research in any reform process. It's clear that we've come a long way in this country. A number of initiatives have emerged in the past couple of years. Recently, you've all heard of a special research fund of 65 million dollars, administered through the NRC, to foster the type of health research that will lead to better decisions. On this issue we are probably on the right track, but we need to do more.

Another issue is that, it's clear that in a time of fiscal constraints the natural reaction is to shovel the load in the other person's garden. Clearly the problem here is that community participation should not be viewed as a way of downloading responsibilities from provincial or the federal ministry. People felt very strongly about the need for communities to be involved in making decisions.

But, they need to be involved creatively. People who are in decision-making positions have to get all that creative energy into the decision-making process, rather than downloading the problems.

Finally, regarding the wish list to the Minister of Health, ministers in the provinces and the Forum, I have just a couple of key final messages. First, I would come back to my central message that health care reform should not be fiscally driven. Then, the issue of information was crucial throughout the debate. We need to reinforce information systems to make sure that information flows across the system.

Another important message to the ministers of health was that they have to approach issues in collaboration with their colleagues in other ministries. I think the biggest risk here is for ministers of health to feel that they have to solve all the problems of society. That all the solutions to society's problems should come out of their budget. This is a crucial error, and I'll come back to it in a moment when we discuss this central issue of defining health and health care.

Here are a few personal reflections.

On the concept of determinants of health, and more particularly on elaborating an operational vision of health, in the health care and social services system. I believe that the realization that we are covering new ground should lead us to move cautiously in expanding the concept of health. From an operational perspective, we must be careful not to dismantle what we have in place right now, or to

jeopardize the good that we have accomplished to date, because it is clear that Canadians are very attached to their health care system.

Dr. Nadeau defined health as the "outcome of work, education, and community support." She alluded to the one essential element that is common to all: income. Income is the most important determinant of health. Having made this statement, however, Dr. Nadeau led us down a path I can only describe as slippery. Indeed, it's the paradox between emotion and reason.

You may be aware that this is a topic dear to the collective heart of Quebecois. The paradox, then, is that individuals are concerned with illness and therefore place great store in the health care system, while the community is more inclined to look at a broader vision of health and put greater store in work and education. I'd like to ask: where is the paradox? Human beings are complex animals with emotions, the capacity to reason and, in some cases, they aspire to a "transcendent truth.". Because humans are complex in nature, the challenge is to make sure our health care system addresses every element of their nature.

This said, it seems simplistic to suggest that any evolution of our health care system is based on the triumph of reason over emotion. That proposition seems somewhat Cartesian when the goal is to overcome the fear that Canadians have of losing their health care system.

Fortunately, Dr. Kenny re-established a balance, in my view. In fact, when she said that the objective was indeed to put forward solutions likely to reconcile the evolution towards a broader system with a broader vision of health, while at the same time safeguarding the benefits of our present system, she reassured me that all points of view are in fact represented on the Forum.

In closing, I'd like to draw a conclusion from the interesting and complex discussion on expanding the concept of health. It is called population health. It is: the fundamental challenge we face here in Canada in 1996, is to come up with an operational definition of health. If we recognize that income is the most important determinant of health, we're saying we should not attempt to solve all of our health problems by looking at the health budget. We need to look at many other factors like job creation, as well as economic and political stability.

I'd like to discuss another topic I feel is important, and it's very much a sacred cow nowadays, and that is regionalization. What I find surprising about regionalization is that it's a theory that has spread very rapidly. Theories don't often spread that fast so it's interesting to ask ourselves "why?" The answer is probably a combination of reasons: increasingly, decisions will have to take into account the individual and the information at hand. As well, politicians had a lot to gain by pushing this theory, particularly in communities that stood to benefit from new facilities or services. It's an experiment that's relatively recent, so it's important now to stop and consider the benefits, the costs, and the risks, and how to maximize the benefits while minimizing the downside.

CHARLOTTE GRAY

One of the most interesting things being up here was, what a very different approach each of the four of us has taken to the assignment we were given today. I'm going to sound rather superficial after some of the previous speakers, because, being in the health media, I'm given an assignment and I stick to the assignment. But, one of the other interesting aspects is that all of the groups were given the same questions to consider yet there really has not been much repetition in the reports we've given on what the groups said.

The three groups that I covered did reach one overwhelming consensus. There's a need for a national structure to continue the dialogue on health and health care in Canada. There was debate about whether this should be a federal structure, or a federal/provincial/territorial structure. But, there was a feeling that there must be somebody who takes a stewardship role for Canada's health care system. There's tremendous admiration for the work the National Forum has done. And a real fear that once the National Forum is dissolved, the stewardship role will go with it.

So it's fine to say we need a national structure. What should the national structure do? What would be its responsibilities? Chiefly, it would be responsible, according to the groups that I listened to, for the vision of Canadian health and health care. With the emphasis on health, because everybody recognizes that the delivery of services in health care are provincial responsibilities. There's a clear assumption that the federal government will continue to shape the consensus on the indicators of health and the objectives in overall goals of the health care system. And to make sure that the health care system continues to embody the values in this system which typify us as Canadians.

How will it do this? What tools does it need? Now, this is where we come back to endless, endless, endless discussion of evidence and information. The kind of points that arose in the discussion I heard were, that we need consistent information collection across provinces, with federal coordination of that information. We need to identify, what is being done well, and share that information. We need to know what's going on in each province, so provinces can learn from each other. We need to make sure that information and evidence has enormous credibility, so there's a lot about the kind of new systems and how you get on top of the emerging information technologies.

But, there was also a recognition that evidence-based decision making is a great phrase. But when you're talking about the politics of health care, evidence often doesn't come in to it. Political decisions are not be driven so much by what we know is happening within the system, as by many other factors. There's a recognition that there's a real need for credible information. Partly, the whole issue of a national structure came up because of the impact of the restructuring that all provinces are all going through in different ways. And a sense that there's been no strategy.

Two of the groups spent a lot of time on what have been the impacts. What's been the effect of having no overall strategy for the restructuring of the government. And, just to put it briefly, we must recognize that rationalization and restructuring create other costs although it's always been driven by the need to cut costs. Often it is just a way in shifting costs. But there are incredible costs

for people we've not even considered: families, national organizations, volunteers, First Nations and the multi-cultural groups within Canada. We're not even thinking about whether these people's needs are being met by the systems that are emerging.

I heard a strong need to re-determine who the gatekeepers in the system are. As one group said, "medically necessary" is too narrow a definition in a broader base population health system. We have to think how people get into the system? How do they access it? Who are the health providers? And we need bridge funding for the transition to community care.

We know it's happening. We know we are moving out of bricks and mortar into care delivered in a different way. But there simply isn't, at the moment, enough support for that transitional process. As one person said, you know when you start painting your house it's going to be in a mess, but you also know your going to get a better house in the end. Canadians are losing confidence because a) they see us getting in a mess, and b) they don't know what will be the end result. And that's very destabilizing because it means people are losing confidence in the health care system. There must be more support during the transitional phase.

Two groups were absolutely emphatic that bills C-91 and 92 must be revisited. There's a strong sense that we need to look at those issues again. The emerging issue is the role of the private sector. There was no consensus in the groups on whether we want it. Despite that fact, it's already happening. And again, we need a plan, with standards and a framework which is going to be determined jointly between the federal and provincial governments.

Finally, we come to the *Canada Health Act*. Everybody loves the *Canada Health Act* in this group. But once you said that, it's a bit like "I'm a feminist but...", it's "I love the *Canada Health Act* but..." We want to both reinforce support for it and its five principles, but also to redefine its principles. People are stumbling over comprehensiveness the whole time. What does it mean? And what does it cover? And, in particular, how can we in a broader sense look at the *Canada Health Act* and ensure that we can extend it to cover community care?

How does our direction relate to the *Canada Health Act* and its five principles? And then there was one remark I thought was really worth reporting. One person said, "It's not just health and health care that we may have lost sight of in the restructuring and re-invention of government. But we may also lose sight of what we want from government, and perhaps we ought to think about that too."

Now, as I said, being in the health media, I'm given an assignment and I stick to it. So, I reported on the groups I attended but then I was asked to give some personal reflections and observations on the last two days.

I have to start with, "Well what were my expectations?" What were any of our expectations? And I have to say that when you arrive at an airport hotel, one of the problems is your expectations are that you will be going to go off to a wonderful place, you don't usually go to the airport hotel to stay there. I arrived hoping we might all go to a wonderful place. But I also arrived with a degree of

cynicism. I was introduced as a member of the health media. Somebody spoke yesterday about the tyranny of the media. And certainly the media in terms of the National Health Forum has been fairly cynical, because despite the undoubted hard work of the Forum members and some very substantial accomplishment in terms of pulling together ideas and research, there's always this question of who is listening? What impact can it have?

Also as a political writer I felt some of the discussions took place without the political context ever being there. Now this is important and valuable in that you don't want to have every discussion distorted by the "Is it do-able?" angle. But also the fact is that the federal government's role in health care is very circumscribed and sometimes I think we tend to forget that.

Also, it took three hours yesterday for me to hear people start speaking the same language. At one point, I was trying to get stovepipes and lumbar punctures separated in my mind. What insights did I get? And what did I hear from others at the conference? The first is the incredible commitment to our public system of health care. I was really, really struck by how strongly committed people are to it.

The energy level, I realized by the end, is in fact triggered as much by frustration as anything else. Real frustration that so much of what we heard over the last two days is what we've been saying for ten, or fifteen years. In fact, back to the Mark Lalonde document of 1976. There's a frustration that if we know all this, how do we get there?

I was really struck, too, by the desperate need for evidence and the exchange of experiences. Some of my most interesting conversations, and I'm sure everyone's found this, have been in corridors and at lunches, where one actually hears what is going on. Where one can hear about the problems of early discharge or why someone is on strike in Halifax, or what's happened to community care in New Brunswick or Alberta.

You realize the fragmentation of the system and the lack of coordination and the lack of information exchange, you realize this is why we are getting health policy made by stealth, as someone put it; it's not the scientific knowledge that is missing, it comes back to the whole point about needing a national body. We just don't know what's going on elsewhere in the country.

So I found great energy and great enthusiasm, but I also found two fears. One fear which was generally expressed in one of the groups, was that this is going to be another report that ends up on the shelf. This was widely expressed, not in a doom and gloom pessimistic way, but in the sense that we mustn't let this happen. The Forum mustn't let this happen; we really want action. And my concern, my private concern, was that we ducked some of the big issues, particularly the whole issue of privatization, which we know is on top of us. We recognize it, but we are still framing it in 1970s language. We haven't grappled with it and unless we do it's just going to happen.

APPENDIX C

National Forum on Health Dialogue:
Seeking Solutions to Health and Health Care
Stakeholder Conference Questions

1. Balance Between Health and Other Social Spending

The determinants of health approach emphasizes the importance of factors outside the health care system -- income, education, environment etc. -- which impact on health status. As shown in the table below, Canada spends relatively more than other industrialized countries on health services and education, but much less on income security programs. However, there is no clear discernable relationship between crude measures of health status and public expenditures on social programs.

	Public Expenditures as a % of GDP			Health status indicators	
	Health	**Income Security[1]**	**Education[2]**	**Life expect. (years)**	**Infant mortality (/ 1,000 births)**
Canada	7.4	11.9	7.1	78.1	6.3
France	7.3	20.5	5.5	77.3	6.8
Germany	6.0	16.8	4.1	76.1	6.0
Italy	6.2	18.5	5.1	77.6	7.9
Netherlands	6.8	23.0	5.6	77.3	6.3
Sweden	6.2	26.3	7.5	78.1	5.3
United Kingdom	5.9	18.5	5.1	76.3	6.6
United States	6.2 (7.4[3])	9.4	5.3	75.7	8.5

Source: 1993 OECD data, with exceptions noted below
1 1990 expenditures on pensions, unemployment benefits and other income support schemes
2 1991-92 expenditures on all levels of education
3 including tax expenditures re: private insurance

1.1 Do you believe that Canada has achieved a reasonable balance of public expenditures in these three key areas which impact on health? If not, how would you reallocate expenditures and based upon which principles and objectives?

2. Balance Within the Health Sector

It has been widely acknowledged that our health system needs to move away from the traditional medical model towards "wellness" models which better embrace the concepts of prevention, health promotion, population health and the determinants of health. However, as governments pursue their efforts to get their fiscal house in order, monies are less likely to be made available for new investments in health, and much of the savings achieved through cuts to health care services will likely be directed towards deficit reduction.

2.1 Health system resources are allocated to sectors as displayed in the table on the next page. Which sectors are overemphasized, which are underemphasized? What concrete improvements in health status would you envisage arising from a reallocation, and over what period of time? Which population groups would stand to gain the most, and which, if any, would stand to lose?

Sector	Share of total expenditures (%)	Sector	Share of total expenditures (%)
Hospitals	37.3	Home care	1.4
Other institutions	9.8	Public health	5.0
Physicians	14.2	Health research	1.1
Other professionals	8.5	Capital	2.9
Drugs	12.6	Other*	7.1

Source: Health Canada, 1994 expenditure data
* "other" includes medical devices, prepayment administration, ambulances, etc.

2.2 With all the uncertainty created by the restructuring and streamlining of health care services, efforts to change attitudes and behaviours of users and providers will likely be met with considerable scepticism. Which health care provider groups or organizations would you identify as being most receptive to change? How can they be involved in leading the system towards changes in attitude or behaviour? Which groups seem most resistant and what are some strategies for bringing them more centrally into the reform process?

3. Public/Private Financing

Currently, public funding accounts for some 72% of health expenditures in Canada, slightly lower than the average in OECD countries. The current break-down of public and private funding by category of expenditure is as follows:

	Expenditures ($B)	Public/Private %
Hospitals	27.0	90/10
Other institutions	7.1	70/30
Physicians	10.3	99/1
Other professionals	6.2	14/86
Drugs	9.2	32/68
Capital	2.1	75/25
Other*	10.6	70/30
Total	72.5	72/28

Source: Health Canada, 1994 data
* "other" includes home care, public health, research, medical devices etc.

3.1 Which values, principles, and objectives and criteria do you believe should guide the allocation of resources (public and private) of the future? What type of decision-making framework would be most suitable in the Canadian context (additional information to be provided on frameworks prior to conference)?

3.2 Assuming that no additional funding was available for the health system as a whole, and that the overall public/private share were to remain unchanged, in which categories would you increase or decrease the share of public and private funding? Give concrete examples for each category.

4. Organization of Health Services

Financing, delivery and allocative mechanisms are three key defining features of health care systems. Analyses of health care reforms around the world suggest that while market-type approaches do not appear to offer any particular benefits on the financing side, they may have potential to improve efficiency in the production and allocation of resources (e.g. managed care, public competition). However, there has been little evaluation yet to determine the impact of these market-derived reforms on equity and effectiveness.

4.1 Recent structural reform efforts in Canada have focused mainly on decentralization of decision-making from provinces to regional authorities, and centralizing certain functions upwards to the regional level. Do you believe that planned market approaches used in some European countries could be adapted to the Canadian context? Should Canadian jurisdictions continue with a "wait and see" strategy or is the time right to take some bolder steps, even in the absence of hard data on the effectiveness of market-driven approaches?

4.2 Given the extent to which the "regionalization" trend has spread across Canada, what do you consider to be the key additional structural changes which need to be made to health care systems in Canada? What are the barriers and opportunities? How do you see the role of your organization in this process of change?

5. Pharmaceuticals

Perhaps more than any other sector of health care, the pharmaceutical sector presents a number of challenges which cut across economic and social interests. New technologies are emerging at an accelerating pace, and cost pressures continue to build. At the same time, access to prescription drugs is not universal, and there is ample anecdotal and scientific evidence of inappropriate prescribing and utilization behaviour throughout the system.

5.1 From a public policy perspective, do you believe the balance of power and accountability in the pharmaceutical sector is appropriate? If not, how should it change?

5.2 To the extent that "supplier-induced demand" plays a role in this sector, what are reasonable checks and balances which society can place on the activities of the various players to promote health policy objectives without compromising their economic freedom?

6. Determinants of Health

There is a growing consensus in Canada that there are many factors which affect the health of individuals and the population. Our understanding about "Why some people are healthy and others are not" is being informed by research in Canada and internationally on the physical, social, economic, psychological and cultural factors that affect health. The need to focus on the health of the population is becoming increasingly more important as a result of the current social and economic environment. We are living in a time of tremendous social change - changes in the

nature of work, in family structures and relationships, in the structure of institutions etc. and in a time of personal and economic uncertainty.

Policy makers face some difficult decisions about finding ways to develop fiscal policies during a time of reduced economic growth while trying to maintain a social environment that continues to support the health of individuals, communities and the nation.

Given all of these competing factors, and the current knowledge base on the determinants of health, the biggest challenge seems to be to find a way of moving from research to action.

6.1 Do you agree with these statements on the determinants of health? If yes, what are the implications to policies, programs and resource allocation if a shift to a determinants of health approach occurs?

6.2 Priorities

What should be the key priorities for policy and program development to create conditions which promote the health of individuals and communities?

(a) What groups are at risk? How do you address the issues for the population as a whole and for at risk groups?
(b) How do we create conditions in workplaces, schools, homes, community sites?
(c) How do we organize work? What changes are needed in labour policies? In tax policies? In the transfer of income to individuals, regions, provinces? How can we re-organize resource allocation?
(d) What changes are needed in child care policies?

6.3 Partnerships

How can we build new partnerships to create strategies to address the problems that result

from these times of social and economic uncertainty ?

(a) Who are the key players?
(b) How will their roles change?
(c) What are the catalysts for change?
(d) What are the tools?
(e) What are the obstacles?
(f) What outcomes/results are desirable?

6.4 Coping with change

Changes are occurring in the health care system which are having major impacts on the social and economic health of individuals, families and communities. How can communities be equipped to deal with these changes?

7. Culture of Evidence-based Decision Making

Evidence-based Decision Making (EBDM) applies to decision making at all levels in the health care system: policy, providers, management and patients. EBDM is driven by the need to ensure the highest quality of health care for Canadians at a cost that is affordable for all Canadians.

EBDM is the systematic application of evidence to the evaluation of options and decision-making in clinical, management and policy settings. EBDM presupposes that evidence exists and that it has been validated in some manner.

Evidence has always been central to health care and health policy. However, it is only one of many factors which influence decisions. In many cases values, for example, are important factors in the patient's evaluation of risks and benefits. In addition, as in many fields of endeavour, there is always a lag between the development of evidence and changes in behaviour. For example, smoking continues to be a challenge despite the evidence available of its negative health impacts.

7.1 If we had a well-developed culture of evidence-based decision making, how would the health system of the future differ from today?

7.2 Should/can we strengthen the culture of evidence-based decision making in the health system? If so, how?

8. What is Evidence?

EBDM presupposes the existence of good and valid evidence. However, this is not always the case. Evidence can be costly to collect or difficult to access for privacy reasons.

In addition, there is the difficult question of validation. When is there evidence enough to result in

real change? For example, this has been a particularly troublesome and value-ridden question in the area of AIDS treatment. It has also been a challenge in the area of new technology as the rate of development can outstrip the rate of published material by which to evaluate new technology.

There is also the question of what is good evidence. There is much data arising from studies using methodologies which are rooted in scientific principles but do not fall within the traditional scientific method, e.g., the Whitehall studies. This problem of validation becomes even more challenging when we look at aboriginal healing or alternative therapies. If a treatment or choice has been valid for native communities for hundreds of years, can it be valid for us without spending years in clinical trials.

8.1 What constitutes evidence?

8.2 What do you do about new technologies that are promising but not evaluated? Should we develop an intermediate position between proven and non-proven?

8.3 Should alternative/complementary therapies or traditional therapies from other cultures be subjected to the same standards of evidence and effectiveness as Western medicine? Are the standards of evidence themselves variable depending on culture or the view of health in which one operates?

8.4 Do you think different cultural or ethnic groups should be able to decide for themselves how they will meet their health needs, and to use public funds for treatments and therapies which are scientifically unproven and not generally used in the health care system?

9. Health Information Infrastructure

The availability of quality information on which to base our health decisions is essential. For example, a great deal of data is collected regarding expenditures in the health care system, but relatively little is gathered on the effectiveness of these expenditures. Bringing all the relevant information that exists today to bear on an individual clinical or health policy decisions is the challenge facing the health information infrastructure.

One technique being used at the clinical level to better apply knowledge to decisions are Decision Support Tools or DSTs. These are tools which integrate patients signs and symptoms with historical data and rules to provide the user with a decision or range of decision options.

A related issue is how to help consumers and patients make better decisions about their health care. Most of the reliable information about health and health care is very complex and technical and designed to be accessed only by practitioners. Even if it is accessible, how do we ensure that patients are capable of evaluating this information in an effective manner? Information has traditionally been

provided only to health professionals as they have been the ones trained to understand and interpret this information.

9.1 What is the health information infrastructure needed to support evidence-based decision making in Canada? How do we get there from here? What do we have to do to get there?

9.2 What types of decision support tools do we need to put in place to promote the health of Canadians? What types of information should we be collecting, analyzing and/or disseminating?

9.3 What kind of tools and information do we need to put in place to improve decision making by health care providers and policy makers?

9.4 Can patients/consumers be equal partners in making decisions about their own health? What information do people need as patients/consumers/public to strengthen their role?

10. Values and Principles

Although there has been much public discussion in various Canadian provinces about the need to institute sweeping changes to the health care system, there has been correspondingly little discussion in the health reform agenda of the importance and significance of underlying values and principles. We know far too little about the impact of large scale health reform on our individual experiences and our publicly held values. Values set the boundaries of the debate and an understanding of values is viewed as crucial to understanding and predicting human actions and attitudes.

All Canadians do not share the same values, nor are all these values particularly amenable to change. Conflicting or areas of value cleavage suggest that public policies cannot wholly capture or reflect the plurality of Canadian values. However, it is nonetheless important that for future recommendations and policies to be understood by Canadians, they must be framed in a way that resonates with the values accepted as being relevant and valid.

This list of values and principles (by no means an exhaustive listing) is to be used in answering the questions which follow:

(i) Efficiency: The health system should be as efficient as possible. Services and programmes should be effective, used appropriately, and delivered at the least cost possible.

(ii) Comprehensiveness: The range of services should include all treatments and services that meet health needs.

(iii) Quality of Care: The quality of care available to all Canadians should be as good as, or better than, other countries.

(iv) Patient Autonomy: Patients should have maximum choice in deciding what services and treatments are available to them, and under what terms they will receive them.

(v) Equal Access for Individuals: Every Canadian should have equal access to health care. Ability to pay should not be a barrier.

(vi) Equitable Shares for Groups: Resources should be distributed so different communities and population groups get equitable shares.

(vii) Neediest First: Resources should be distributed on the basis of need; the needs of the neediest should be met before or ahead of the needs of the less needy; resources should be distributed to individuals and populations in proportion to their need for them.

(viii) Maximum Benefit for Dollar: We should strive to get the most "bang for the buck", or benefit for every health care dollar.

(ix) A Healthy Population: We should strive to make as great a positive impact on the health and well-being of the Canadian population as possible.

(a) From the above list, select your most important three values or principles and your three least important ones? Explain your selection. Are there any values or principles you think should be added to the list? What values do you think should be deleted from the list?

(b) What conflicts do you see as potentially developing among or between these values, and how would you resolve them?

11. Right to Health Care / Allocation of Resources / Government Priorities

There is widespread support for Medicare and for the values and principles embodied in the *Canada Health Act*. We also know that a high percentage of the population rates the health-care system as good to excellent. Recent research shows that Canadians consider health to be the third most important value, out of a list of 22, that the federal government must uphold. It ranks only behind such fundamental concepts as maintaining freedom and providing a clean environment.

(a) Do you believe that all Canadians have a right to health care, and if so how would you qualify this right? A right to basic services? A right to quality services? A right to the best health services available?

(b) In terms of determining health policy, which of the following do you think is more important for government, and why ? i) meeting the needs of those who are most sick and vulnerable? ii) improving the overall health and quality of life for Canadians?

12. Allocation of Resources / Palliative Care-Acute Care / Fairness in Waiting Lists

Many of the difficult decisions in the arena of health care reform involve making choices about how society will use its available resources. These resources are finite and, in comparison, our capacity to extend the range of medical services seems infinite. Many argue that we must bring a balance to the system whereby instead of wanting every new incremental health care benefit regardless of cost, the public understands that to have more health care services entails having less of something else.

(a) How important do you think it is to ensure that the needs of the dying are met as fully as possible compared to trying to save lives when chances of success are very poor?

(b) Interventions to save lives are often very expensive. Do you think we put too much emphasis on saving lives at any cost at the expense of not meeting other important needs?

(c) Do you agree that in some instances it may be necessary to limit the options available to an individual patient in order to ensure that resources are shared fairly among all patients?

(d) How would you rank the various criteria listed below for prioritizing people in a waiting list for a medical service? Are there any that you feel should definitely not be used, and why?

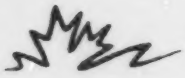
1. Medical urgency
2. Benefit to the individual
3. Benefit to society
4. Age
5. Lifestyle factors
6. First come, first serve

13. Inequalities / Resources for Health - Health Care

One of the original cornerstones of Medicare was that all would have equitable access to services, regardless of ability to pay. Many have argued that even if it could be proven that a single, public, universal system for what is deemed medically necessary is in some respects inferior to a combined private-public system, we may still not be justified in moving to that latter. It may be that Canadians value equity and universality over alleged higher quality for a select few.

(a) We tolerate many inequalities in Canadian society. Some people have big houses, others live in the street. Some people drive fancy cars; others cannot afford to buy a car at all. Is inequality in health care different than in other areas of life? If so, why?

(b) Moreover, if health care is only one of the determinants of health and the other determinants of health are themselves unfairly distributed, should health care be any different? If so, why?



APPENDIX D

Group 1
Question 3: Public / Private Financing
Saturday, April 20, 1996

Question 3.1: Is the current public / private allocation optimal?

Allocation

Strengths:

- Some benchmarking
- Cost control in areas high public finance proportion
- Avoids risk selection (no cream skimming)
- Lower administration cost
- Accessibility increased in public area
- Financial protection for the sick
- Reduced bad debts for providers
- Enforcement of principles
- Public funding reduces burden on employers
- Economical comparative advantage for Canadian producers

Drawbacks:

- Poor integration of public / private - odd assignment of services to public or private
- Incentives to cost shifting → private
- Expensive - innovation restricted - confused accountability - waste ?
- Historically driven split - no long range approach / analysis
- No change - intertia
- Transitional funds
- Comprehensiveness -
    - - Canada health act / public + hospitals and MD's
    - - other services - predate
    - - delisting
- Accessibility reduced in public because of cost control / cutbacks
- Quality decreased / compromised to save $ in public sector
- Can we do more with less?
- All decisions become financial decisions - and politicized
- Incentives to play cost shift game
- Private is growing → is this good?
- Incentives to delist
- Allocation problems within public - Accountability
  - Responsibility
- Cost control by private insurers increase as cost increase → managed care
- Need to work together / communicate / share responsibility
- No measurement of quality / outcomes

Key Messages:

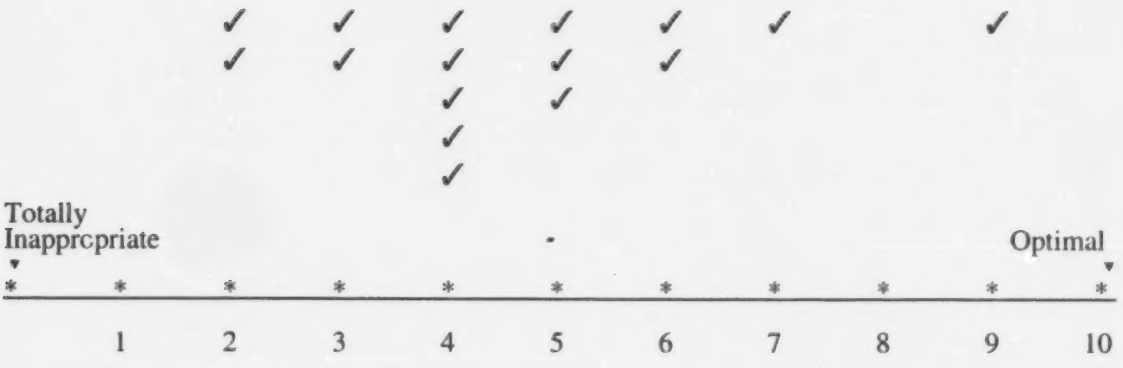
1. Need goal to determine "optimal"
2. Public level too small to ensure quality / accessibility
3. Defining quality of care

4. Health impact is negligible (define health and health care)
5. Use information / evidence in making funding decisions
6. Need vision / goal approach
7. Problems with balance
8. Incentives to cost shift
9. What's in / what's out - needs redefinition

Current Public / Private Allocation

(Participants perception of the current balance)

Financing



Definition of optimal:

- Related to achievement of Canada Health Act principles
- Accessibility / quality objectives
- Efficient - reduce waste

Question 3.2: Which values, principles, objectives and criteria do you believe should guide the allocation of resources (public and private) in the future?

Principles / Objectives:

1. Need
2. Shared respect, including individual responsibility
   - Define criteria related to principles
     - who defines, client
     - scope?
3. Integrated approach with other than health care services and within health
4. Quality of care
5. Reflect determinants of health - particularly factors beyond industry control
6. More client - focused
     - prevention where possible
7. Increase individual / family / community capacity to work with existing resources

- reduce risk
- increase participation

8. Focus on consumer education
    - may be public
9. Control / partnership between public / private
    → (e.g. publicly funded system → costs on private)
10. Health is basic need access to health care is a fundamental right → public funding of Canada Health Act
11. Equity / efficiency / security / liberty (need trade-offs)
12. Not just public or all private → mix
13. Canada Health Act principles
    - "comprehensive" needs redefinition
14. Health system not illness system
15. Choice
16. Build on the best
17. No room for profit?
18. If it's needed - public pay?

Key Messages:

1. Quality
2. Universal accessibility
3. Joint decision-making
4. Canada Health Act

Question 3.3: What type of decision making framework would be most suitable in the Canadian content? (How do you view the current versus alternative models of determining the scope of public coverage?)

Frameworks:

- List
- Professional judgment and peer review (e.g. TIMO, MO, Reg. HC)
- Patient (vouchers / medical savings cost)
- Shared decision-making (who)
- General categories - who / where - Canada Health Act
- Who makes decision
    - MD's
    - people
    - government
    - other providers
- Macro or meso or micro decisions
- Use of evidence (where possible)
    - values
    - preferences
- List has to be flexible and able to use new evidence
- Point of service determination
- Multi-disciplinary approach
    - global budgets

    - incentives related to desired outcomes
    - relative values
- Between pure evidence and political process
- Decisions are political
    - who makes decisions
    - how selected
    - accountability

Key Messages:

1. Flexibility versus predictability
2. Implicit versus explicit
3. Multiple screens has appeal
4. As objective as possible
5. Skip Oregon
6. Decisions are being made now
7. Do we believe there is enough $ for medical necessities
8. Clinical guidelines
9. Taxation as tool of funding
10. Coordination of policies

Question 3.4: Assuming that (No additional) less funding was available for the health system as a whole, and that the overall public / private share were to remain unchanged, in which categories would you increase or decrease the share of public and private funding?

- Define "enough"
- Population / health versus individual / health decisions
- More public health
- What's effective / appropriate
- Evidence
- Why assume "less" funding - population is increasing
- If Canada Health Act principles apply → public funding
- Public share can be political / philosophical decision

	Private Pay		More $	More Public
27	Hospitals	10%		
7	Other Institutions	30%	--	
10	MD's	1%	--	
6	Other Professions	86%		+
9	Drugs	68%		
2	Capital	25%		
10	Other	30%	+	
72	Other other		+	

- Costs controlled in public-funded sector
- Impact of financing on delivery system
- If advised care is not necessary and won't be publicly funded - should private payment be permitted
- Need health indicators
  - population-based
  - public pay
- Have to decide what to buy at all - where to buy and how to pay
- Set goals / acceptance / price it
- Private can deliver high quality, efficient / effective care
  - can be controlled
  - can be done within public financing
- Systems can affect efficiency

Key Messages:

1. Define core generic services
   - in public funding system
   - comprehensiveness definition
   - medical recommendation

in gray out
area

2. Others can be considered a private commodity in market
3. Comprehensiveness equals medical necessity
4. Patient choice
5. Choices are distorted by what is publicly financed and what's not
6. Need for definition of what's in - but lists have advantages and disadvantages

Question 3.5: What is the ideal role of private insurers? Should it change or remain the same?

Ideal Role of Private Insurers:

1. Cover services not covered by public system
2. Risk must be controllable (reduce moral hazard)
3. If comprehensive coverage - all medical necessity - then no need for private
4. Costs are driven by public system
5. Competitive model - compete with public insurance and provision (voucher system / fund holder) but multiple payers could
    - raise costs
    - cause equity problems
    - destroy support for public
6. Need public system at core - supplementary to private
7. Alternative sources of funding → avoid cost control
8. Public system can attract patients and providers
9. If you can afford to pay for something beyond public level → why not pay increased taxes?
10. Choice is notable – above base
    – supplement
11. Increased costs → decreased competitive advantage
12. Out-of-country coverage
13. Health is not a commodity but some aspects of health care may be
14. Incentives to government to cost shift
15. Risk selection is an issue

Key Messages:

1. Supplemental
2. Competition for services
3. Out-of country → pre-existing conditions
4. If public system covers all comprehensive (medical necessities) including alternative delivery / providers - services - no need for insurance because only for elective procedures
5. If equity is important → public system
6. Economic efficiency
7. No consensus that health care is a commodity

Group 2
Question 4
Saturday, April 20, 1996

Question 4.1: Do you believe that planned market approached used in some European countries could be adapted to the Canadian context? Why or why not?

Why's

- We would be forced to define what is insured. Why not - population density.
- Real possibilities - if properly structured
- We have made decisions
- Competition among providers
- Incentives needed to improve efficiency - market, planned - doctor or provider decides
- Won't work in rural setting
- Big spender - need for efficiency
- Don't wait until system is broke - need to look at this
- Trust market system to weed out problems
- Decision-making tool - assists in effective integration

Why Not's

- Haven't been evaluated
- Values differ
    - Canadians don't want to be rostered
    - British works because primary cure in place - can't be transferred here
- Evidence before we move
    - pilots - only way - serious
- If market - means flip, flop then research difficult - lack of stability
- Driven by industries
- Not clear market works in industry - will it in health care, but incentives are within
- No more bureaucracy
- What are we trying to fix - can't sustain it
    - more effective integration
- Purchaser / provider split
    - need integrated at local level
- Careful who purchaser is?
    - provincial - local
    - criteria - who sets
- If single corporate structure
- Planned market solution in search of issue
- Who will make decisions?
- Why bring in another system from outside?
- Ability to make decisions
    - information - technology
    - uninformed consumer
    - knowledge / wisdom
- Definitions - not same e.g. health and health care

Approaches

1. Paid volunteer (UK) and others
2. Fund holding practices
   - (purchasing power in hands of primary care "specialists" accountability - administrative costs)
3. Private insurance - by industries
   - regulated financing (some build facilities)
4. Nursing home - personal / care (Manitoba)
   - needs driver - internal competition
5. Long-term care
6. Dying - places to go to (Britain)
   - people prepared - relief to acute care facilities
7. Preferred provider
   - specific providers
8. Two-tiered system
   - (one tier - right to basic essential services - define what we pay for - medically necessary)
9. Monopolies - pro's and con's

Planned Market Approach

Internal competition among providers - within publicly funded system

Yes - Why

Already have among physicians, hospitals (informal), e.g. lab services

a) cost efficient - quality - repetition
b) internal competition - referrals - quality indicators
c) informational - public opinion
d) politically - support for competitive model - private sector
e) - small "c" conservative driven philosophy of self-reliance

Why Not

Patients - disadvantaged
Must be close to home

e) single payer implications
   - bureaucracy
   - perceived to save money
   - cost effective
   - private business has to satisfy customers

- GP fund holders not trained as managers
- Workforce could be abused
  - no benefits - more low income
- Difficulty for research and education
- Imply profit - if health care for profit - whose?
- So what happens to money not spent on rostered patients
  - (boards to determine who should get it would help)
- Cultural approached - different
- Rural areas - competition - attracting - high costs
- Values and quality get lost
- Risk for increased bureaucracy and administration costs

- Community based services
  - appropriateness
  - private sector behaviour
  - case management
  - works if implemented with "single entry"
- Use selectively
- Two-tiered - symptom of a planned market approach
  - it is a "why not"
- Two-tier for essential services undesirable
- Universality has to be addressed - for core services
- Can't buy privately - services publicly funded
  - will introduce problems in public systems

Question 4.2: What steps (if any) should Canada take with respect to market-driven approaches?

- Explore and understand market-driven approach in Europe
- Understand what the prerogatives of national government are
- Establish time lines
- Provinces need to be seen as the engine
- Define the goals:
  - jurisdiction - (First Nation)
  - needs
- Jurisdiction
  - federal
  - provincial
  - local
- Empower communities
- Evaluate it, and decide what we want to use it for

Question 4.3: Given the "Regionalization" trend, what do you consider to be the key additional structure changes which need to be made to health care systems in Canada?

- Reductions of the ministries of health
- Restructuring at the ministry of health
  - federal
  - regional
- Fund regions based on population
- Organized system for primary care
- Information systems
  - primary care
- Composition of boards
  - elected
  - appointed
- Transferring of authority
  - provincial → regions

- Feds have to get out of policy linked to delivery?
- Address on how we pay doctors
- Link with teaching and researching

Key Implications of Regionalization?

Positives: "We hope"

- More responsive
- More flexible
- Better continuity of care
- Comprehensive programmatic approach (specialized needs)
- Break down artificial barriers
- Cost savings
- Clearer lines of accountability
- Define health much more broader
- More empowerment
- Competition in the system (bottom up)
- Innovation in research and education
- Public becomes more involved in the allocation of resources
- Visibility of choices made
- Making choices based on total picture
- Integrate planning and operation
- More precise business planning
- Able to exploit equal opportunities
    - people
    - technology

Negatives:

- Not maintaining universal standards
- Maintaining same quality of service
- More vulnerable to special interests groups
- Responsibility without authority
- Less clear lines of accountability
- Authority without responsibility
- Boundary definition
- Larger bureaucracy (potential)
- Possibility of poor management (lack of skills)
- Potential of elected or appointed process - being political
- Hidden bureaucratic costs
- Loosing economy of scale
- Risk of too much devolution
- Job loss:
    - young
    - newly trained
    - highly skilled
- Failure to recognize transition costs
- Loss of funding for research and education
- Moral issue

- Dominate society making the decisions
- Reassessing

Question 4.4: What are the barriers and opportunities associated with anticipated structural changes?

Barriers

- Friction between three levels of government
- Money
- Adequate local expertise / resources
- Don't see the need for change
- Friction between disease management structure and regions
- Inner professional cooperation
- Time
- Political will (Ontario)
- The risks
- Open endedness ($) for legal action
- Old institutional loyalties
- Existing boards
- Alienation of physicians (cause or effect)
- Existing legislation on transfer payments
- Different evaluation criteria

Opportunities

- Learn from past mistakes
- Financial hard times is forcing us to act
- Citizen education about health and financing is positive
- Facilitates vertical integration
- Ombudsman
- Upcoming election
- Education from grass roots up
- Evaluate and study the experiments
- Better planning for health care
- Health care workers more sensitized to value for money
- Client centered satisfactory service
- More open discussion for the general public
- Integrate healthy service body (non-political)
    - provincial or federal

Group 3
Question: 5
Saturday, April 20, 1996

Accountability Key Message

1. Current balance of power and accountability in pharmaceutical sector is complex and is perceived to be inappropriate
   - → the "why" of this is because we have not yet addressed a range of policy issues with implications for different stakeholders who are often adversarial

Accountability of many players in the provision of drugs to the <u>public:</u>

(- not equally powerful)

- pharmaceutical sector
- prescribers
- government(s)
- health care providers
- consumers
- pharmacists

Roles ➤ Shifting

Issues:

- sometimes ill-defined
- sometimes ignored
- sometimes poorly understood among players themselves
- quality control problem (i.e. not simply need for more "knowledge")

Issues Requiring Attention

- Cost
- Utilization
- Prescribing practices
- Drug advertising
- Access
- Data
  - → availability
  - → quality
- Research usage - EBDM
- Degree to which accountability structure is coordinated , i.e. hodge-podge
- Systemic culture (of health care), i.e. stove-piping, quick fix
- Systemic driven barriers/ perverse incentives, i.e. fee-for-service, confidentiality
- Behaviour(s) of consumers
  - appropriate expectations
  - of patients
  - of prescribers
  - role of media
  - Place of alternative therapies
  - Safety

- Quality-control deficit
- Information management (balance "signal to noise" ratio)

Proposed Adjustments

1. Expand coverage of Canada Health Act to include all effective care (including drug therapy and "alternative" medicines
2. Remuneration systems
   - modify "fee-for-service" as only approach for
     - ⇒ physicians
     - ⇒ pharmacists
   - to reflect "cognitive" reimbursement
3. Improve evidence availability and quality
   - ↪ learn from quality control failures
   - ↪ effectiveness
   - ↪ common data base incorporating consensus on rules of evidence
4. Establish "arms-length" medicine review / control organization
   - ↪ review drug approval system
   - ↪ national system
   - ↪ accountable to government
   - ↪ track drug utilization, safety and effectiveness
5. Align incentives among players in the sector
   - ↪ fee for service
   - ↪ remove barriers between pharmacists and physicians and with other health care providers (e.g. know one another's knowledge base, fully utilize team approach)
6. Coordination of primary care system
   - ↪ principles
     - no individual profit from prescribing decisions
     - savings in one area redirected into others transparently
     - organization of MOHs, budgets, etc.
     - incentives to have appropriate mix of practitioners and resources to keep the patient group healthy
7. Communicate "error signals" in a timely way (relevant and timely feedback to decision-maker)
   - ↪ small area variations
   - ↪ use of technology / computers
   - ↪ need to get relevant information to physicians (user-friendly systems and technology)
   - ↪ have standards
   - ↪ use "speed bumps"
     - – i.e. deals with how individual patients will react / changing habits
8. Expand national standards for drug advertising
   - ↪ what can be claimed for an individual drug
   - ↪ reflect shift to evidence-based medicine (beyond efficacy)
   - ↪ optics used in the advertising
     - honest
     - in good taste
     - non-sexist
   - ↪ bring in the advertising community
     - part of debate

- move from driving the industry
- → expand standards for advertising for OTC medications to the public

Supplier-Induced Demand: Checks and Balances

Questions:

- Is this a true market model? Should it be?
- How much profit is enough?
- How does this fit within "effective care"?
- Should new medicines be viewed within a market model?
- Is drug development a "business"? Should it be?
- Where is appropriate role for market?
- How best to get to the people who need them?
- What drives / supports new drug development?
- There is "violent agreement" that there is an imbalance
  - → what checks and balances are appropriate

1. Advertising to physicians strictly regulated (i.e. evidence-based)
2. Accountability for patient outcomes are held by physicians and pharmacists (based on patient needs)
   - → pay for outcome not activity
3. To get on to Canadian market, new drugs must be efficacious and effective and continuously monitored for safety
4. Address "supplier inducement" elements of fee-for-service system
5. Address "consumer-induced demand" elements
   - → enable "cognitive reimbursement" to enable time to be spent with patients
   - → support consumer education by all health care providers
   - → introduce level of care to provide education to patients (not currently reimbursed in system)
   - → expand successful existing models (involving all players)
   - → increase access to successful existing model
6. Improve organization of primary care
   - → liaison among all community health care providers
   - → organization and delivery of education for primary care, so students exposed early to cooperation with range of providers
   - → make appropriate use of health care providers - "cultural" issue among providers

Bill C-91

- To what extent has this legislative framework created the issues we are trying to address?

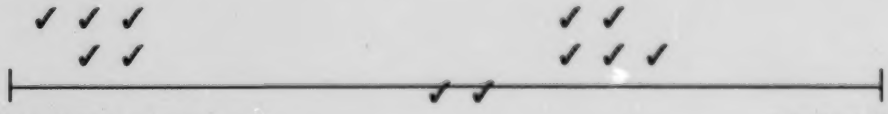
- Segment:
  1) drug development
  2) profitability levels requirements

- Clarifying what we really want from a drug development industry in Canada
  - → what economic / social arrangements are required to support

Group 4
Questions: 1-5
Saturday, April 20, 1996

Question 1: Balance Between Health and Other Social Spending

Current Balance:



Absolute imbalance — Perfect Balance

Adjusting the Balance in the Future

Perception of Participants as to Desired Shifts in Allocation

	Health	Income Security	Education	Total $
Current Allocation	40%	20%	40%	100% of current envelope
Idea Allocation	8	9	8	
Change	↑	↓	↑	

Principles and Objectives

- Increased education $'s will lead to better health
- Leave health spending as is
- Re: income security - solution is to create jobs
- Issue is not only real allocation, but also total $'s / GDP, therefore, increase % of GDP or decrease ?
- Increase $'s for education, but in the three sectors, increased emphasis on the children
  *accountability should be a key principle and evidence-based, affordability, and respect levels ofdecisions
- Leave health $'s same, decrease income security, increase education
- Increase education: better bang for the buck
  - ⇝ educate re: use of health care
- Access is an issue (e.g. mental health)
  - ⇝ therefore, $'s for health should increase
- Re: evidence-based → decisions about allocation should be made within a framework
  - ⇝ must define criteria
  - ⇝ need to think about how to use $'s effectively

- ↳ need to focus on long-term
- ↳ therefore, increase $'s based on long-term gains, as opposed to short-term crises

- Value for money
- Better management
- Needs-based planning
- Re: education → need to devote more attention to outcomes, not necessarily more $'s
- Need to include health education in education strategy (wellness module)
- Need to include other sectors (e.g. transportation) in this discussion

Key Messages

- Bi-polar re: balance - group is divided on assessment of current balance
- Not asking right questions
  - ↳ $'s don't cover everything
- Education versus important
  - ↳ (long-term needs-based planning)
- Social security could "give"
- Conditioning statements re: principles
  *National, long-term perspective
  *Value for money, bang-for-buck
  - ↳ needs-based planning
  - ↳ accountability, affordability
  - ↳ outcome-oriented
- No consensus re: education / income security
- No one has said we should cut more in health care
- Better management needed in all three areas:
  - ↳ outcome-based"
  - ↳ "value-based"

Objectives for Balance Between Health and Social Sectors

- Better health outcomes
- "Effective citizenship" - holistic approach to wellness
- Reducing health inequalities between men / women, income groups
- Improve access to appropriate effective care in a timely manner, based on evidence
- In sync with demographic changes
- Target lost productive hours
  - ↳ therefore, reducing work days lost due to illness
- Redistribute from "last" days of life to first days →
  - ↳ therefore, improving balance between reducing suffering and creating health
- Increase emphasis on quality of life, as opposed to length of life
- Bring health services as close as possible to patient
  - ↳ therefore, accessibility, quality of life
- Cost-effectiveness
  - ↳ need to find and implement cost-effective interventions
  - ↳ reduce overall expenditures without compromising quality / effectiveness

- Structure spending around health objectives and priorities
  - ↪ therefore, identifying priorities first
- Health envelope cannot solve all problems → need to coordinate different sectors
- Prevention is key objective
- Target resources to populations in <u>need</u>
- Vertical integration of services is important to rebalance $'s
- Continuous quality improvement
- Population health may be too broad a target for health sector interventions
- We need to have "operational" objectives
- Re: vertical integration - it's not clear that the trade-offs are best done at the local level

Question 2: How to Reallocate Spending in Health Sector?

- Increase public funding for complementary health care only if supported by evidence
- Increase $'s to improve administrative support and information systems, "quantum leap" is needed
- Reallocate towards health education
- More community-based care versus institutional
- Prevention in health promotion
- Priority for high need and disadvantaged populations
- Shift to chronic, away from acute
- Increase $'s on health research (basic and applied)
- Move from acute to palliative
- From drugs to doctors (e.g. Germany)
  - ↪ need to put a lid on rising drug costs
  - ↪ better accountability re: profits
  - ↪ more effective use of drugs (i.e. use cost-effective therapies)
  - ↪ improve access
- Reallocate to allied health professionals

Objectives

- Better outcomes
- Redirect health inequalities
- Improved accessibility
- Quality of life / duration of life - better balance
- Closer to home
- Continuous quality improvements
- Improved cost-effectiveness
- Respect ethics

How to Achieve Objectives

- From institution to community-based
- More preventative and promotion
- More to high need groups
- Increase chronic, away from acute

- Increase research and information systems
- From acute to palliative
- Increase use of complementary health care providers, based on evidence
- Increase use of allied health providers

Question 3: Public - Private Financing

Issues:

- Comprehensive - the more private funding, the more you erode comprehensiveness in the public system
- Public funding facilitates maintenance of standards
- Fairness → in accessing health care based on ability to pay
- Uncertainty - managing physician / patient interface when public sector withdraws
- Public acceptance of not being able to access private services (limitation of choice)
- Limited public resources
- Control of the total cost of the health system
- "Allocative inefficiency" by having publicly funded services in certain settings, but not others
- Administrative costs - private administered systems have higher administrative costs
- Timeliness of access (waiting lists)
- The possibility of introducing market mechanisms within the public system
- Public will
- Concern re: erosion of middle-class support for public system with the introduction of privately-financed services
- Profit → should private corporations be allowed to make $'s from health system?
- Publicly financed one-tier system alleged to freeze out innovation
- Private has the risk of being profit-driven and not needs-driven (assuming profit-driven means not needs-driven)
- Re: access → two-tier system will magnify inequities between have / have-nots
- Could we carve out or expand private system for non-medically necessary services and what would be consequences?
    - → *need to clarify medical necessity
- Americanization of Canadian health care
- What percent of private spending that public system can support ? (not all or nothing)
- Fundamental justice in treatment / remuneration of health providers
- NAFTA - implications re: access by foreign partners to market
- Need to adapt the idea of medically necessary to today's realities (e.g. drug medications)
- Introduction franchise, co-payments, and co-insurance
- If private funding increases, it reduces the incentive to improve efficiency of the public system (need to avoid institutionalizing inefficiencies)
- How to look after people if financing modalities change (e.g. Oregon / Medicaid)
- Risk of losing physicians to U.S. if we don't maintain or increase private $'s
- Why keep the possibility open of injecting private funds into the system, when efficiency of these services is uncertain

Values and Principles

- Basic assumption: that the five Canada Health Act principles are in place
- Expand Canada Health Act's principles
  - → e.g. "humanity"
- Administrative efficiency should guide public / private split
- Accountability (more than just fiscal)
- Affordability
- Integrity re: medical necessities
- Public sectors should not finance services that are not medically necessary
- Continuity of care
- Accountability (more than just fiscal)
- Maintenance / protection of provider / patient relationship and closer to home
- "Medically necessary" should include holistic approach, reflect a more expansive notion
  - → bio-psycho-social aspects

Key Messages

Issues:

- Standard setting
- Maintaining access
- Uncertainty
- Questions of choice
- Cost control of system
- Administrative efficiency
- Management of waiting lists
- Medically necessary - need to redefine
- Fundamental justice
- Americanization (NAFTA)
- Institutionalizing public sector inefficiencies
- Basic assumption:
  - → five Canada Health Act principles

Why Public / Private Debate?

- Perceived inefficiencies in public system and can't afford
- Expand access to services ("smorgasbord syndrome")

Question 4: Planned Market Approaches: Can They be Applied in Canada?

Principles

- Need to evaluate European models before adopting them
- The federal government should abandon the health, social and education sectors in favour of provincial autonomy
- Keep national standards (monitoring and compliance)
  - → but provinces' transfer payments "operationalize" the system
- Greater acceptance of alternative care (acupuncture, homeopathy, midwives)

- Re: Europe → the country pays for central administration of the system (different from Canada)
- Domestic markets in Sweden and the UK may be interesting to study (but it may be too early to evaluate)
- Therefore, principle - define at each level what is necessary and contract out for services (all within single-source public funding)
- Need to balance supply and demand
- Make sure accountability and authority go hand-in-hand
- Need to evaluate impact of CHST re: outcomes and access
- If one adopts the idea of internal markets into the Canadian system, there is a risk vis a vis Americanization
- But we are competitive
- *Need to tie source of money to use of money (e.g. workplace health)
    - → in Sweden / Germany

What Steps?

- Before going to a market-based approach, we need to know the costs of production
- Need to have clear understanding of service standards (safeguard for quality)
- Also need to monitor performance re: standards
- Need public education re: rights to services and quality
- We need to know how much money is available to invest in such a system
- Need to evaluate the impact on collective agreements (is it feasible, will they need to be revised?)
- Need to change legislative framework and possibly constitution if we want to allow parallel private system
- Need to specify very clearly what the goals are and not shift everything to the private side (e.g. health and promotion)

What New Changes re: Regionalization

- None! - need to take time to evaluate
- Have we gone too far, too fast with regionalization?
    - → some components could / should be centralized → e.g. public health
- It would we necessary to regionalize and integrate other systems (e.g. education)
    - → conditions of success
- Need to ensure regionalization does not leave some groups with inadequate services (e.g. First Nations); need to have community-based facilities in place first
- Regional structures need to integrate primary care services funding
- Secondary / tertiary care → should it be funded at provincial or regional level?
- Need to consider cost of regionalized structures (and benefits)
- Regionalization may increase balkanization of coverage across regions
- * Need to step back, define objectives of regionalization and evaluate experience

Opportunities

- Having manageable-sized self-contained systems where you measure outcomes
- Increase investment in importing competitive technology to make a leap in productivity and avoid duplication
- Canada Health Act universally available health care portability, single payer

- Reallocation at the community-based level
- Opportunity to integrate decisions / services across sectors
- Current fiscal "crunch" allows us to do things we wouldn't otherwise be able to do
- Fiscal "crunch" opportunity to be more creative
- Regional authorities is a "test bed" for pilot projects

Barriers

- Canada is a large country - diversity of regions, have / have-nots; geography is a barrier
- Canada Health Act itself is both an opportunity and barrier (accommodative factor and resistor)
- Strong public opinion is barrier
    - → "Medicare is most popular program"
    - → Strong public support
- Fiscal crunch also barrier when people who have power also have to give it up

Key Messages

Lessons Learned

- Need for evaluation
- Recognize trade-offs between national / standards and provincial-autonomy
- Integrate sources and use of funds
- Further potential for regionalization and decentralization
- Accept wider range of alternative service providers
- Separation of purchasers / providers

Next Steps

- Take stock of where we are
    - → federal funding changes regionalization
- Need to define / monitor standards
- Legislate reviews
- Educate public about need for reform
- Define pool of $'s
- Examine impact re: labour
- Need to clarify "market-driven"

Questions re: Regionalization

- None (need to step back)
- Gone too far already
- Integrated approach
- Who controls envelope of secondary / tertiary services

Question 5:The Current Balance of Power and Accountability in the Pharmaceutical Sector

Power and Accountability - Working Well

- We're getting the medication for diseases that need to be treated (e.g. inhibitors)
- They're channeling funds into research
- Regulatory process works - drugs are safe
- Pharmaceutical-sector is a great asset for national economy (economic development and growth)
- Ability to substitute more cost-effective therapy
- New sense of obligation and cooperation between manufacturer, providers, prescribers, consumers?
- Increase in accountability re: usage studies and pharmaceutical companies - economics before drugs are rolled into system
- Some companies are studying impact of their products on quality of life
- Incorporation of cost-effectiveness in the clinical trial process
- Information network / systems which enable monitoring of side-effects, drug utilization
- PMPRB has maintained patented drug price increases below CPI

Power and Accountability - Not Working Well

- Drugs for common illnesses are not always available
- Research - drug companies may not be meeting commitments under Bill C-91
- No post-market surveillance of drugs - once available, can be prescribed for any use (no monitoring system for potentially inappropriate usage)
- "Marketing" of drugs to doctors does not inspire optional use
  - → pharmaceutical companies need to establish deontological relationships with doctors
- Pharmaceutical companies should finance medical training organizations, instead of financing the doctor
- Patient compliance is an area for improvement
- Re: antibiotics, physician is caught in middle, need to make sure antibiotics are not over-prescribed
- Direct advertising of products to public at large is a potential problem
- Harmonization of drug approval process (Canada, U.S. other)
- Extension of drug patents protection (C-91) is a cost issue
- Consumers do not have the information they need about drugs
- The relationship for the patient between technology and illness
- Duplication of efforts by ten provinces having their own formulary
- Also ten separate systems of drug distribution

Suggestions for Improvement

- Need regulation for post-marketing surveillance and drug utilization review
- Need to improve patient compliance
- Need international / concerted effort on part of ministers of health to harmonize drug approval process
- Give PMPRB real teeth to regulate prices
- Need to develop incentives to promote drug utilization review (e.g. Ontario is using formulary as mechanism)
- Need for consumer education (but need to be careful about who provides information)
  - → has to be partnership of key players
- Harmonize distribution System

Working Well	Not Well
• Drugs available • Better jobs re: research • Regulatory process working well • Formularies are good • Increased economic development • Good partnering, PMPRB has made prices reasonable	• May not be living up to C-91 commitment • Need more post-market surveillance • Duplication of formularies • Conflict of interest - physician / industry • Non-compliance is big issue

Suggestions for Improvement

- More post-market surveillance
- Make PMPRB stronger
- Harmonize drug approval process internationally
- Increase use of formularies and reduce duplication
- Consumer education needs to be enhanced

Group 5
Questions: 1-5
Saturday, April 20, 1996

Question 1: Balance Between Sectors

- Concern about public expenditure on Canadian health
- Relating data with gender differences
- Spending right amounts in the right areas
- Other indicators not in list, need more information
  - → certain groups
  - → diverse country (cultures . . .)
- Could see Japan figures
- We do have reasonable balance compared to Sweden (we're spending less)
- Data not static
- By the time we analyze, it's too late
- Cuts already too much
- Our health care system in its infancy, infrastructure, not complete
- CHST will pit groups over smaller public funds
- Negatives impact on general health
- There isn't a reasonable balance - never has been - lots of political questions
- Shift away from sources of funds: costs going up and corporate taxes going down
- Social spending not increasing (pat on the back) (→ Annex from Art Kube)
- Health care is not a "system" at this point
- We are facing a conflict of values, a paradox - say one thing and do another
- Was system set up to care for illness?
- Inefficiencies in system - can we do more (or the same) with less ?
- We loose track of issues relative to children:
  - → poverty (food, shelter, clothes)
  - → cuts to funding
- U.S. figures don't factor in private $$
- Not looking at other elements impacting on health
- Discord between politicians and public on what's important
- Social aspects (services) impact on health and health services inverse proportion
- Social spending not synonymous with transfer payments
- Our health care system is advantageous in international trade
- Too much focus on deficit reduction
- Is Forum used as a tool to support government policies (Red Book) to make it look like people were consulted?

On Question of Balance

1. Not enough information
   - → is total appropriate ?
   - → are we maximizing efficiency?
- We are spending 24% less than many other countries in '93
  - → results show we're effective

- Statistics not important - need guidelines
- Define standards
- What are the outcomes we need
- Standards should be Canadian
- Role and responsibility of government to do what individuals can't do by themselves
- Long-term costs not calculated on social expenditure for medium and long-term care
- We're not using our reduction on health and health care issues
- Deficit reduction happening on the backs of poorer people
- Media and corporate deciding on deficit reduction as the issue

Canadian's values have not changed so much

Polls show Canadians want national standards

- Forum should remind politicians of what Canadians want and don't want to change
- Governments are elected to address Canadian concerns - not their riding, not to get re-elected
- Reallocation should favour EDUCATION
- Community health people should guide government in balancing
- Money management (by government) in conflict - politics versus need
- Impact of social expenditures on JOBS

Question 2: Balance Within the Sector

Objectives of shifting balance:

- ↪ Develop integrated, seamless system in which outcomes are the determinants, therefore "evidence-based"
- ↪ How to make the change ?
- ↪ Bring service to the community FIRST before cutting back ★
- ↪ Savings in one area sent back into improving the "system" *

- Re-aligning system to guide re-allocation of funds *
- Environment in a state of instability and unpredictability *
- A Political Plan - for stability ★
- Look at Big Picture - costs of going to community-based services
- Do we have ability to maintain quality?
- Include prevention - promotion
- Currently - we're doing more than meets the eye
  - we are efficient
- No evidence showing efficiency of moving from institutional care to home care
- "Taking things out of hospitals is cheaper" is wrong

- Impact on home care giver (transferring responsibility to)
  - cost in absenteeism
  - is mostly women
  - erosion of wages
- Going to home care too early is costly in long-(medium) term
- In system, we're providing same quality care as five years ago
- Complexity of system doesn't allow to have data on impacts
- Need to look at trends instead
  - ⇝ down in institutional care
  - ⇝ very little investment in research and capital
  - ⇝ trend in drugs is going up
- Plan strategies over more than the life of Δ government
- Change in governments negatively affect plans
- Nurses can't give same quality of care as before
- Substituting professional care by uncharted care
- Data available on early discharge: negative effect
- People in system are still giving the best they can give
- Patients see other factors - <u>waiting</u>
- Quality care not always cheaper
- We don't understand what is needed, can't plan for it on long-term basis
- <u>Must Plan !</u>
- Reforms are on the way: Have Goals and Plan
- Might cost in short-term
- Value and funding formulas must relate to each other
- There should be re-allocation
- Review N.B. experience
- Have consistency and simplicity in plans
- What are other methods of delivery?
- Consumers must be included in planning and other phases
- No need for consultants

Question 3: Public - Private Financing

Key Issues

- Private services may be a barrier to access
- Issue could / will create a two-tiered system
- Subject softening Canadians up to tiered system
- Views from business
  - support for core services in system
  - private sector: management of targeted sector not now covered
- How private money comes into the system, should enhance not detract
- What private sector does with its money in the system
- Careful in defining core and comprehensive care
  - ⇝ i.e. may enhance support service
    - information technology
    - keeping equal access
- Bring more $'s into the system - core services should continue <u>to expand</u>

- Are grants, training, equipment considered funding?
- Clearly identify those core services that are public
- Universality to be applied to health and health care
- Areas for Private (e.g. home care) versus Public
- Defining "private funds" - anything not coming out of the taxation system
- Demands from consumers is to be able to pay for services but we're constricting choices
- Drugs are one area that should be funded
- Home, long-term, rehab care is growing as a private sector interest - concern quality of care and access
- Government will allow private sector to get in as long as there's no fuss
- Should enhance quality of care with private funds:
    - → as investments
    - → or increased efficiency of delivery
- Labour issue with unionized staff with low wage labour
- Maintain standards when going form public to private
- System in evolution, so should funding sources for services and drugs
- Objections to the question !
- Forum has pre-conceived ideas on values . . .
- Can't talk about financing without talking about delivery
- To consider ethics, quality, efficiency, equity - not just public / private funding
- Protect consumer

Question 4: Planned Market Approaches: Can They be Applied in Canada?

- Should make our own model, value-based, Canadian
- Principles
    - → meant to give greater choice
    - → improve quality
    - → consolidating services
    - → contracting out non-medical services
- Implications: start-up time ± 36 months to efficiency
- Level of character of "care", medical or not, changing, going lower
- Impact, medium-long term, of going to private suppliers
- Social costs of downsizing, less pay, children poorer, women bearing the brunt
- Considering social s human interaction in contracting
- Costs of social impacts not "factored in" in business plan
- We're not looking at impacts of managed care system:
    - → training
    - → research
    - → tertiary and
    - → health care
- Expensive services got maintained
- Profit in high volume - low intensive care
- Canadian workforce high quality - motivated, caring but we're not taking advantage of this resource
    - → promote growth in system
    - → profit from multi-skilled staff
- Find positive aspects of market-driven approach:

Flexibility in client-provider interface

- What business are we in?
- Find expertise not available in our field: databases
- Where is the accountability? For what?
- Increasing costs of contracted-out work, plus institutions cutting off these services puts them in an obligation to continue buying services
- Public system can follow principles guiding market - based approach
- Not looking for "bottom-line" driven system
- Physicians should care instead of managing contracts, which cost in administrative time

Barriers

- We don't really have a system its silos
- Research base
- Hierarchy-based
- Opposition to change
- Tendency for over specialization
- Problem with multi-tasking
- Issues with workload, training
- Accountability with respect to multi-tasking
- Responsibility with respect to multi-skills
- No development funds for change
- Decisions political
- Single year budgeting
- Additional structural changes
- Non-acute care (long-term women)
- Meaning and impact of regionalization
- Evaluate and plan apolitically
- Role of academic sector
- Maintain and enforce standards already in place
- More regional boards accountable to communities
- Concern with building in disparity between regions
- Sharing of funds and provision of all levels of care

Question 5: Balance of Power and Accountability

- No !
- Industry
- Physicians
- Drug Plans
- Public
- Technology
- Government Regulations
- Increase of spending - twice in the last decade!
- Research must stay in public domain
- Bill C-22 - monopoly by manufacturer pushing overall costs higher
- Need for research on cost of replacing brand by generic drugs
- Too much power with drug brand names

- Go back to four year protection
- Government can't influence drug industry / companies
- Canadian support to putting balance back in
- Government should not bow to pressures of companies (R&D or moving out)
- Advertising to physicians influences prescriptions

Checks and Balances

- Public education by industry
- Ensure EBDM by physicians in prescribing
- Regulations on use of prescription patterns
- Prescribing evidence
- Joint provincial / federal agency to provide information on drugs
  → efficiency versus cost
- Control about claims in marketing and advertising
  → in a code
- What's the force behind the drive for this change
- Considering regional interests
- "Cheerleaders" in form of researchers / academics
- Some provinces have positive model / pilot projects with regards to referenced-based pricing
- Gets positive response
- Universality of drug plans
- Proper use save costs
- Industry should be part of process
- Education for public on what's going on and drugs themselves
- Look at ownership of generic companies
- Research on dosage should be gender related
- Technology for tracking
- Zero tolerance for substance abuse

Group 6
Questions 1-5
Saturday, April 20, 1996

Question 1: Health versus Other Sectors

- Figures (1993) out of date
- Level of public expectancy on social policies bad and getting worse
- Merit in developing health goals and shift away from medical model
  → contributes to vision government responsibility
- Concern re: cuts to health transfers to province
- Concern re: level of spending - health, welfare, etc.
- Haven't really looked beyond health care system re: allocations in other sectors
- Review of Canada Pension Plan - further chance of cuts to income security at the same time as cuts to health - impacts across all age groups - especially the most vulnerable
- Compounding impact over life stages
- Sufficient funding in medical model
- Continuum illness → wellness and desired shift → cuts → serious impact regarding being just
- Can reduce illness-based costs and shift to other areas
- Some view re: mutual balance between health and other sector - not so much the problem - real issue is whole social policy area is under-funded
- Better balance by <u>not</u> cutting health care, but move into income security from other policy areas / other areas of social economy
- Envelope is the issue - but within also look at balance
- Need to recognize high debts <u>is</u> a drag on the overall economy and desired fiscal flexibility
- Need to also look at values underlying social policy <u>and</u> other policy areas - what do we <u>stop</u>
- Other view - re: benefit of policies (e.g. tax cuts) re: more miserable society for <u>some</u>
- Deficit reduction shouldn't be at the expense of the poor
- Don't see consideration re: <u>investments</u> for the future, e.g. community economic development
- Need to sort economic policy from ideology
- How big is the pie and how to divide it
  → where is this taking us re: society - we will have survival of the strongest ? ?
- If we don't accept it, what do we do
- Health Canada not in competition with income security and education
  → problems if this is the view - if envelope more ideal, might look at balance

Key Messages

- Health care can't stand much more cuts
- But doesn't mean don't need to look at reallocation in health care, i.e. to make health spending more socially oriented
- Don't accept premise re: debt is rationale for restructuring spending - also see government withdrawal (proportion of health $'s re: total economy)
- Goals = vision which is needed
- Statement re: social goals to assist resource allocation decisions
- Need to recognize globalization and potential for job loss, unless favourable "environment" re: world but business perspective versus social policy perspective

→ governments not good at creating jobs

- Federal budget needs to reflect determinants of health
- Can't afford not to invest socially

Question 2: Principles / Objectives re: Reallocation in Health

- Effective outcomes → does it work
- Canada Health Act principles - core of system
- Need to deal with issues of transition
- Look at consumer utilization / in appropriate demand; levels of physical incomes; i.e. areas for efficiency re: where and how $'s currently being spent
- Need to look at needs / uses of system for various population groups
- Need for planning to ensure a balanced system
- Need short term and long term goals / measure and a plan
- Need to look at the original values of the Canada Health Act and not just principles
- Models of care that work for various health problems are not necessarily best provided by physician - team approach → client-focused
- Look at shift to community / home care re: costs - not less costly
- Need to revisit what the publicly funded system includes (e.g. drugs were to be next . . .)
- Where is the infrastructure for community / home care going to come from - register this as a concern (who is the community?)
- How do formal and informal care providers need to link
- How can we build in incentives and choice for consumers - often not part of discussion re: financing
- Effort needed in terms of rationalization of entire system - communication within and reflection re: coordination of system - education - consumer and delivery sides
- Don't have a system focused at primary care and client level - this could create less need for higher level of service
  → also need increased quality assurance
- Pressure / demand for diagnostic services by public
  → education of consumer and their responsibilities is needed
- Need more controls on use of services - users must be given incentives re: a primary care physician - responsibility of government and professionals
- No paper-tracking re: health consumers - free to move around and no "trail"
- Areas to improve:
  1) Home care: Why? Quality of life → can't shift to health care without adequate support
  2) Primary Care: Why?: focal point re: population health issues - first contact re: determinants of health and preventative treatment
- * Quest re: validity of figures
- Problem with the question → based on traditional service areas - e.g. primary care missing
- Want to move to focus on provider teams at primary care level - i.e. need to look at restructured system
- Is it primary care or more broadly primary health care - (i.e. community development)
- Role of informal / volunteer care providers (families) not recognized
- Respite care, etc.
- Issue beyond just allocation of $'s
- Look at alternatives to current structure (e.g.: N.B. extra-mural hospitals, single entry for senior to resident care)

- Multi-disciplinary primary care such as a community health centre model
  - → i.e. more the principles this implies
  - → CLSC model in Quebec → i.e. more to a "wellness" model / in some communities an economic lifeline as well
  - → Community Health Organization model
- Will require some creativity re: current federal funding system
- Need to educate politicians re: primary health care / health promotion is an investment in the longer term

Key Messages

- Move to primary health care - but need to clarify terminology
  - → i.e. change of current role of primary care and the mix
  - → i.e. change the nature of services - not just allocation vis a vis current system
- Important links throughout the continuum
  - → including "pre-primary" care and health education in schools
- Can't be an exercise in saving $'s
- Will mean huge changes re: consumer and provider expectations

Question 3: Public / Private

Key Issues Re: Balance

Definitions: re: Public - insured / Canada Health Act
Private

- Rationalization of Canada Health Act versus cuts in transfers - especially for poorer provinces
- Roles of public sector versus private
- Impact on cost control
- Greater opportunity in public side
- Access - e.g. home care / costs
- De-nationalization of standards → as Feds. pull back - greater impact on provinces
- Who will enforce - especially if less emphasis on standards
  - → police themselves
- Why would we want more privatization?
- Sign of out of control costs
- Taxpayers pay twice
- The more we privatize, can't pull it back - NAFTA - major strategic decision
- Can we afford publicly funded health care but . . .
- Can we afford not to - need to create a greater sense of where $'s are going and choice
- How many $'s do we want to spend and how to finance (taxes versus other)
- Private / market-driven system tends to load greater burden on poor
- Don't want to shift to U.S. system - but are we tinkering with the Canadian model in the right areas
- Assumes people want to shift to private - <u>don't</u>
- Driving force is philosophical difficulty between Feds. and provinces
- F.F.S. also drives
- Feds. and provinces need to get it together

- New science causing a drift and unfairness, i.e. costs are covered if in hospital, but not if patient has moved out
- Transfer payments in health not the same as in other areas - Feds. have responsibility in health
- Difficult choices to keep public system viable - pressures of new technology and drugs
- Resurgent health problems (e.g. TB)
- Decline in physical activity, etc. → longer-term trends we also need to budget for
- Reinforces focus on children
- Biggest costs in last six months
- Governments are beginning to plan for an older population
- Political ideology → pushed to look at more competition, less government, more personal responsibility
- Privatization - delivery and / or payment leads to U.S.
- Is health care a commodity - in Canada - no; in U.S. - yes
- Concern re: problems of U.S. - three-tier
- Health care not a commodity so shouldn't restructure along market-driven lines * a principle
- Strength of Canadian system - publicly-funded but private / non-profit delivery
- Canadians - more benevolent (Medicare and U.I.) *need to maintain
- People view "private" as meaning for profit and in Canada - it is NOT for profit *people need to know and understand
- Health not well done by private market
  - → i.e. private non-profit - public funding and standards
- If we don't carry out reforms carefully, a sector of society may start to push for "for profit"
- Principle - non-profit system / public funding and this is the strength
- Focus so much on balancing budget today and not looking down the road - i.e. emphasizing business principles versus overall economy, e.g. cut in $'s for mental health / increase in prison costs
- Canadian Health Coalition - 10 Goals (see hand-in)
  - → investment in skills of health care providers, etc.
- Those who can afford private insurance
  - → those with jobs / rich
  - → don't want to see profit made from illness
- F.F.S. payments to doctors needs to be looked at - and in the context of roles of other providers - area to cut back
- Some provinces don't believe in Canada Health Act principles (Alberta, New Brunswick) - need federal / political enforcement

Key Messages

- Private versus public
  - → private doesn't mean "for profit"
- Feds. and provinces need to get act together
- Feds. do have a responsibility in health, even though they don't deliver service
- There needs to be greater interaction between various department envelopes
- Health not a commodity - don't use market principles
- If federal funding decreasing - abrogating whole issue
- Ever since introduction of Medicare is federal government's ability to pay - need to continue to put $'s where mouth is re: Canada Health Act
- If Feds. guilty - provinces are too - less $'s available for health and also for other institutions - is there a better way?

→ not U.S. system
→ not market-driven

- The problem really is a fiscal one, public and providers have liked the system - but now we can't sustain; so:

1. Decreased service / utilization * (preferred option)
2. Increased $'s for health
3. Third-party participation via a deductible / pro-rated (* e.g. - may be fall back option)

- Need to "regulate" public / private so as not to cause further pressures on the system
  → private sector is profit-driven and will leave expensive services to public sector - while doing lower cost / higher margin
- Not a fiscal problem
  → Alberta does not have a deficit
  → Medicare didn't cause the debt / deficit
- Regardless, there is less $'s → leading to "tinkering" to find right level

Question 4: Organization of Services
Principles from European Market Approaches for Canada

Context

- Moved aggressively to market approaches and now swinging back
- Also - Europe has a higher level of social spending - so can't compare
- UK - purchaser / provider mentality → association for community living might be able to incorporate this
- Funding for individuals managed by a provider organization
- Need to define meaning of "market-driven approaches"
  → consumer choice
  → competition among health providers for "client / customer"
- Some want to use "buzz words" to change financing
- Principle (within publicly funded system) is that $'s follows patient or client versus services
- To ascertain extent already applied to physician - who have an overall $ cap
- Different approach - rostered practice - restricts or disincentives to using other providers
  * effective choice
  * not applicable in all parts of country
- Could also tender for lab services - so scope of consideration of market services - broader
- Question whether managed care has been shown to save $'s
- What about other options, e.g. move to salary
- Possible principles but not those from Europe

Implications of Regionalization

- Haven't paid attention to developing the models
  → did budgets, governance first - without clear goals versus patient / provider interface
- For provinces that left decisions all to region - reinforced some old power bases
- Need broad performance / health status indicators
- Pay attention to services at the patient level and get these right
- Strength of system at local level and need to sort provincial role - then put regional level in place

- Regional health boards need to be democratic, accountable and representative
- New Brunswick goal - to de-politicize health - but all are patronage appointments
- Regionalization of central authority - not decentralization of authority
- Can improve the system - but need to education the public
- Regionalization - was to control expenses and a power grab
- Philosophy accompanying regionalization key; principles / values:
    - ⇒ Primary Health Care
    - ⇒ Client Focused
    - ⇒ Integration
    - ⇒ Broad-Various Sectors (PEI Social Services and Corrections)
    - ⇒ Public Participation
    - ⇒ Inter-Disciplinary Collaboration
- As power moved to regions, abrogation of responsibilities and demoralization in small areas / institutions - have lost local say (more of a problem in some provinces than others
    - ↬ PEI - positive experience
    - ↬ hope to get to point where provinces decides overall what / regions - how
- Does regionalization equal devolution or centralization
    - ↬ needs to mean appropriate devolution but some centralization will also occur
- Has been hard to get $'s for innovative patient health care since $'s trapped in institutions
- "Elected" boards also create biases when in Saskatchewan - one third of board members are providers; and general public interest lower
    - ↬ key is for provinces to make clear what the expectations are
- Downloading - barrier between provincial politician and community → closer to home doesn't necessarily mean more democratic

Key Messages

- Regionalization - not a panacea
    - ↬ depends on philosophy and goals
- Restructuring driven by principles, not management structure
- Key issue is labour adjustment
    - ↬ if seen as a way to drive down wages
- Principles and values key in PEI → common belief system needed for success
- Workers need to retain rights
- Decentralize envelopes of funding

Question 5: Pharmaceuticals

Question of Balance in Power and Accountability

- Prescribing of drugs inappropriate / too high
- Governments only interested in costs and not safety / quality for consumers
- Opportunity to use objective people to advise physicians on prescribing
- Therapeutic equivalents prescribing - can take a look at safety / efficiency of class of drugs and fund first line drugs → B.C. model
- Pharmaceutical industry - not accountable
- PMPRB - captive to industry for drug information

- Need to empower PMPRB* (current author for patent drugs) to better monitor brand and generic drugs and control prices
- New drugs - artificially high prices
- Sources of information for doctors are biased
- Consumer not well-informed
  → re: appropriate use, etc.
- Need to connect royalties to research
- Need to drive research into areas where growing need but not a big ticket item re: profit potential
- Prefer a non-regulatory strategy → give pharmaceutical companies option to compete and lower prices
- Allows government to save $'s and fund its own resources
- Patent protection remains a problem
- Some positives:
  → good / needed drugs but problem re: costs
- Pharmaceutical companies approaching communities re: projects - creates ethical conflicts for the communities
- Also problems / conflict of interest when pharmaceutical companies move into managing drug plans
- Issues re: confidentiality in drug plan information
- Relates back to need for proper management systems for patients otherwise drug companies could end up owning primary health care organizations and then doctors would be working for drug companies
- Don't forget the benefits / cost-benefits of many drugs
- Issues re: time / education in addressing vague complaints of patients and not jumping to prescribing

Key Messages

- Ethics re: sponsorship
- Utilization
- Cost → solution - regulatory - PMPRB
  - non-regulatory - therapeutic prescriptions
  - restructured system
- Research
- Patent protection problem
- Physicians and patient education
- Savings from some drugs

Group 7
Question 6: Determinants of Health
Saturday, April 20, 1996

Question 6: What comes to mind if using a "determinants of health" approach? What do you see in place, ten years from now?

- Breakdown of professional dominance of service and delivery
- With church involvement
- 10% of population smoke
- All of our children feel loved
- Different payment structure for physicians
- No children feel hungry
- People are more in control of their own health, including death / dying
- Everyone doing work they love
- Increased awareness reached on how to keep healthy
- Social programs which support income security - more than $'s, i.e. housing / transportation
- Use less drugs / medications
- Increased self-esteem
- Schools are site for inter-disciplinary community development / part of system
- Will have "bridge" jobs for young and retirees - notion of career has changed
- Everyone involved in meaningful or unmeaningful work / activity
- People with a problem are treated with dignity
- Less use of acute-care system
- Overcome fear of losing health care system
- Fewer people on streets
- Cleaner / safer environments
- Active environments
- Equitable health - people living with AIDS and other illnesses
- Cooperation and community responsibility are valued more highly by Canadians relative to economic competitiveness
- In 2006, community will treat people with dignity / fairness - supports exist in community
- All elderly see a role for themselves, feel valued and understand what is happening and are involved
- Governments role is what?
  - ↪ set policies
  - ↪ need to be a partner in delivery
- Strategic alliances are working
- A social policy on dying / aging exists
- No mandatory retirement age
- National governments have greater control over global economy
- Greater coordination between health and economic policy
- Well developed information system, including determinants of health
- GST removed from health environment communication systems, e.g. CBC continues to exist to sustain culture
- Policies are fair - issues of access to care / services which will require a major economic shift
- Decrease in suicide rate

- Cost-effective research base to inform policy decisions
- Decrease in family violence
- Assure equal access to health care for seniors
- "Better babies" - prenatal healthiest babies possible
- Avoid supporting industries that don't support health
- Tobacco not available
- Green spaces (natural) environmentally friendly
- Health impact assessment tool or process available / used widely using "determinants of health" wealth, environment, (e.g. B.C. model)
- Canada set a model for other countries / don't export the problem
- Increased educational levels and economics
- Support to children 0-5 years, better babies, pre-schools, transition to schools life-long learning
- Mandatory curriculum on nutrition/ fit / health
- Healthy school and workplace environment
- Inter-cultural understanding living together more harmoniously
- Family-friendly workplace policies
- Self-esteem generating work environments
- Labour adjustment structures to help people cope with job change
- A consensus-oriented government - democracy
- Corrections program to assist people to grow and contribute to society
- Education system needs to change to teach children new models re: democracy
- "Gender" determinants of health
- "Rural" versus urban environments - access to determinants of health not just health care system
- Foster resilience individual / family / community
- Pension system eliminates poverty
- Services to mental health patients to live in community
- Less of a "disease of the month" approach to health
- Less meat → recapturing more basic approach to food / eating a natural approach
- Transportation of foods to northern communities - produce closer to communities
- Comprehensive policy on food security
- Resolution of jurisdictorial issues for First Nations - self-government

Priorities

- Addressing mind-sets attitudes re: dependence and interdependence in society
- Examine how health care system enables and limits the determinants of health approach
- Look at which part of the system is primed to change and build on success
- Stop research / study and implement what we know
- National Forum On Health needs to develop the plan to implement
- National Forum On Health needs to recommend a process for change - focus on the tools for change
  - → e.g. - health impact assessment
  - - ombudsperson for health
  - → who the key players are
- What can the National Forum On Health recommend (2-3 priorities): on policies priorities, partnerships
  - → Louise Nadeau's list
    - financial / taxation

- prevention / promotion
- proof

Barriers

- Physicians in key government positions
- Special interest groups / lobby group
- The silos / stove-pipe approach
- Public understanding of the broader definition of health
- We are in a system held hostage by interest groups
- Interest groups' "power"

Opportunities

- "Determinants of health" - reflected in the definition of health
- Fiscal constraints are so tough obliged to think differently , not respond to interest groups
- Health promotion movement has been weak
- Research base for determinants of health now available
- National Forum On Health needs "to walk the talk" on determinants of health - 'examine' and report on the financing of the formal / informal systems that promote health (public health), e.g. recommendations re: financing of research, reference Senate Report
- National Forum On Health examine system in Sweden that uses evidence-based decision making for financing the system from department of health - gender, income, criteria for funding
- Financing
- Integrating "health" into decision making of other jurisdictions - education influence / don't take it over
- Research funding - build on the momentum of NHRDP support to population health research
- Health promotion research centres
- Integration of population health and health promotion, e.g. three conferences
- Health promotion "is all things to all people" boundaries are too broad
- Determinants of health puts limits to this, difficulty created for research
- Community development approach / model is a "seed" for fostering healthy communities
- Need health information system to help make decisions - need more research
- Need measurement and integration by right people and access / use
- National Forum On Health recommend that minister of health work with Councils of ministers of education using existing mechanisms - comprehensive school health
- Governments set up proper mechanisms / tools to evaluate services in allocation of resources
  - ⇝ fairness
  - ⇝ definition of core services
- National Forum On Health recommend ways to improve decision making

Priorities

- Priority of investment should be children and youth programs for kids as group
  - ⇝ children at risk and support the family
- Work / employment → family-friendly policies - job sharing
- Continue to provide health care services for seniors-in-need (caveat)
- Who gets involved? Partnerships-Cross-Sectoral

- Define what we can / want to achieve collectively that we can't achieve separately
- Consider times of economic cut backs; ability to contribute can be hindered / difficult - protectionism
- Look at where there have been successes
- Define criteria of legitimate partners based on values
- Partnerships only one of the ways to achieve the priorities
- What are the ways to achieve priorities?
- Partnerships are one way - there are others?
- Partnerships need to be in place at community level - also inter-ministerial cooperation for local action to occur
- Need political will / commitment at different levels of government
- Create structures / financial mechanisms and incentives / mechanisms to work together - National Forum On Health recommendation
- Mandate:
    - ⇝ money - incentives, travel
    - ⇝ time - become part of the job descriptions
- Incentives need to be powerful enough to make it happen, e.g. research priorities
- Partnerships force communication - discuss roles, assumptions
- Pre-conditions to make partnerships work
- Need to work on / look at relationships to make partnerships work. Parties must have status, voice, etc.

Group 8
Question 6: Determinants of Health
Saturday, April 20, 1996

Question 6: Determinants of Health

- Those factors that affect our health
- Most determinants outside "sickness care system"
  - → e.g. housing, culture, support networks
- Need those outside health care system involved
- Causality, feelings associated with language "determinant"
- Have evidence now, research available - needs to go to policy
- Want to fight causes of poor health up front
- Forum research covering broad spectrum
- Will not do away with need for health care
- "Health" not uniform through society
- Need integrated solutions and not create problems by addressing others
- Need reflection by public on what makes us healthy
- Some parts of population are more at risk (or believe they are)
- Viable employment,. . . make a difference
- Fear loss of care / services when needed
- How to define community
- Frustrating to see lack of action, based on research
- Health community needs to break out of itself and act with other players
- Budgets historically separate so it's harder to get funding for important determinants,
  - → e.g. transportation to affordable food
- Partnerships critical part of process
- Living in turbulent times
- Look for success stories
- Climate of change may offer opportunity
- Is policy or action our target

Implications of Action

- Passing the buck / stovepipes
  - → who is responsible
- Policy one method of action
  - → e.g. healthy public policy
- Link determinants and action under other "names" and in other sectors
- Have done a lot → need to build on it
  - → e.g. children need housing, education, health . . . .
- Multi-sectoral work is hard
- National platform with more than words
  - → e.g. concrete action plans and targets needed in all sectors / ministries
- Need to address systemic problems
- Need to be able to hold governments accountable
- Accountability for what?

- Need to do what really improves health and well being
- System priorities not well set / assessed
- Determinants a starting point for assessing impact on health
- Determinants by other names
- Need to assess health implications of policies in other areas
- Foster understanding of link between health and action
- Need dynamic process * and flexible approach (recognize mistakes)
- Evaluate . . . . evaluate . . . .
- Determinants are not distinct, but interrelated and fall on a continuum
- Cross sector flexibility * and collaboration
- Frame in language of sustainability
- Courage to put citizens' needs first
- Leadership needed for action
- "Money talks" - tie money to demonstrated collaboration across sectors
- Multiple partnerships - government / business, government / NGO's, business / NGO's
- Hardest part is resource allocation (shifting $'s = shifting jobs)
- Explore impact of investment in one area on outcomes / needs for other areas
- Question notion that there isn't enough money → need instead to focus on decision makers

What are the real implications of adopting a determinants of health approach?
What are the implications of not adopting a Determinants of health approach?
Which populations? Which determinants? Where does the money come from?

- People will always get sick and system needs to be there for people, but returns from health care system are diminishing
- Not an either / or choice
  ↳ why - there could be some reallocation
- Need reallocation within the system and between systems in integrated / coordinated way
  ↳ hospital → home care
- Values provide context *
- Values a driver of change
- Still believe in sick care system
- Need evidence for what to do both in health care system and others
- Where money comes from depends on local / regional needs and current resource allocation
- Health and education inextricably bound
- Target total population - those most at risk will benefit most
- Life-cycle approach → good start in life lasts
- If $ is limited, should those at risk be targeted
- Equity = equal
- Equity achieved by proportional approach
- Invest in next generation
- Water, housing, early childhood development key in South Africa approach
- No guarantees, but want common platform of risk
- Local priorities key in resource allocation decisions
- Step-by-step approach more realistic
- Build determinants approach into other existing programs

Priorities ?

Groups at Risk

Equity is the value used to guide resource allocation, in the assignment of priorities

- Children and youth
- Aboriginals
- Mentally ill / psychiatricaly disabled
- People with disabilities
- Working people - over- / under-employed
- Seniors
- Low income
- General population at risk
- Does "targeting" groups work against an integrated approach
- Should determinants be the focus, rather than populations
  - → e.g. social supports
- Are families / communities at risk?
- Equity suggests those at most risk get more attention
- Evidence so strong about need for healthy child development, but does that pit children against seniors
- How to deal with individuals who don't value health
- Attitudes key in action
  - → "how to get people to buy into action" → incentives
- Prevention of a higher order
- Almost everyone wants to be healthy, but health education to prevent future problems is often not today's priority (safe housing, etc. may be)
- Holistic perspective
- Where does $ go to have the most influence

How to Create Conditions Which Promote Health

- Make schools a community resource
- Introduce graduated retirement
- Increase job sharing
- Increase worker control over job decisions
- Facilitate access to services
  - → e.g. transportation
- Put health on everyone's agenda (how will efforts improve health)
- Remove / minimize "ISMS" from language / action / culture; e.g. racism
- Promote use of early childhood educators
  - → e.g. kindergarten
- Increase community responsibility
  - → e.g. non-parent participation on school councils
- Remove barriers to community participation → increase "civic-ness"
- Involve children and youth in community action
- Involve seniors
- Reward health-promotion efforts
- recognition
- Get media on board to help change attitudes

- Recognize / build in civic behaviour in workplace
- Ensure safety of environments

Changes

- Eliminate either / or choices related to government funding to offer support and enhancement
  → child care, top ups, transitional
- Facilitate change incrementally
- Workplace policies enabling time with children, other family members in need → support, flexibility for family responsibilities
- Better / longer maternity leave (and more flexible work arrangements)
- Less government regulation, but more government leadership, and more business and labour responsibility
- Workplace day care
- Re-examine function of sick leave
- Re-examine work week
- Personal involvement in community decisions
- Foster integration of work and school
  → e.g. more preparation in skills / needs related to work
- Focus on transition points in life (especially for reallocation)
- Broaden definition of work and recognize value and outcome of all types of work
  → e.g. volunteer, housework, child care, paid)
- Flexible work arrangements
  → e.g. 40 hours / 50 weeks / 30 years is not the only positive work contribution
- Better flexibility throughout work life
- Lesson of downsizing
- Comparisons with other places important in setting context
  → e.g. we have a good health care system
- Basic parenting support (validation, connection)
- Foster education / schools as part of broader community / life experience
- Support for child empowerment / active participation / development
  → e.g. children are not just "cared for"
- Child care begins at conception and programs should be designed accordingly
  → e.g. prenatal nutrition
- Support for early childhood development
- Better integration / support for families with disabled children
- After school care
- More flexibility and better integration of parent's work and family needs
- Better injury prevention
  → e.g. better integration of CPR with parents' jobs - e.g. workplace CPR courses
- Parental education
  → e.g. CPR
- Community education (stop signs)
- Teaching of parenting skills to men and women (loss of extended family)
- Role of formal systems ?
- Ned to strengthen role and capacity of communities
- Need to create opportunities for change by all partners
- Foster authoritative, democratic parenting

- Some communities need more help than others → formal system should offer support and capacity building
  - → e.g. Halifax regional support $ for volunteers
- Resources / support needed may vary by locale / community
- Community-based definition of need not renown for supporting disadvantaged groups
- Give national context / standards for local needs assessment
- Risk of targeting is that the wrong groups are targeted

Key Players

- FPT Government: politicians / bureaucrats
  - → health, education, housing, environment, economic development, community social services
- NGO's
- Labour / management
- Education system
- Community-funded
  - → e.g. United Way
- The people
- Religious organizations
  - → e.g. cultural communities - Jewish, Greek, Aboriginal
- Media
- Business
- Stakeholders / service providers / end users / consumers
- Family physicians

Role Changes

- Less government service delivery and more policy, leadership, regulation, enforcement
- Other players need to be clear on government role
- Less competition and more collaboration among sectors / partners
- Maintain and foster partnership with community / consumers
- More genuine consultation, which is time consuming
- Government must take community contribution more seriously
- Need to overcome attitudinal malaise / frustration in some areas
- Define outcomes, conduct evaluation and build in accountability
- Non-partisan collaboration in House of Commons
- Business needs to become accountable to government and community
- Better identification of needs first, then collaborative program development

Successes

- Less hierarchy → more equality of input
  - → e.g. more consultation, free flow of information
- Free flow of information and information systems to support this
- Increased accountability of business to government and community
- Better integration
- More flexibility

- Build critical success factors into programs / policies / projects on which to base evaluation
- Provide better information to the public to avoid too high expectations
- Not focus on repair, but on prevention
- Move beyond health care system
- No duplication
- Combined efforts
- Less inter-group / -departmental hostility through more true partnership (defensive / preventive collaboration) and better leadership / leaders (open, team players, democratic style)
- Modeling partnerships

Family Coping With Change

- Provide information on options to family to enable them to make informed decisions of how to spend $'s to get the best support for them
- Crisis intervention
- Prevent such crises by better policy making / service decisions
- Need to also access resources outside the formal system
- Learn from those who have successfully coped with stresses (research)
- Accentuate people's strengths and past successes
- Good advance planning to prevent problems
  - → e.g. for hospital stay
- More accessible crisis services in a more timely manner
- Previous generations experienced major changes and may offer "survival" lessons and skills
- Research to measure coping skills
- Evidence-based policy and program development

Group 9
Questions: 7-8-9
Saturday, April 20, 1996

Question 7.1: Evidence Based Decision Making (EBDM) - Vision of the Future

- Ministries would be integrated
  - i.e. Health, Education, Social Services
- Integrated information systems
- More uniformity between health and health care delivery
- More attuned to resources available
- Address real quality of health outcomes
- Delivery of care will be based on health outcomes
- Stronger research and evaluation component at all levels
- Policy evaluation becomes routine
- Research reflects both academic and community researchers
- Access to evidence
- Process to deal with lack of evidence
- Where there are gaps in evidence, resources are clearly identified
- Patients / clients will demand to know what the evidence is
- Consumer as part of the team → same access
- Outcomes presented a way that is clear and useful
- Be cheaper
- Action component to each piece of research
- Fewer acute care beds
- Health care / health services would be community-based and inter-sectoral
- Culture would value an holistic approach
- Value industry / community response
- There is a culture of constraint on decision-makers
- Quality of health care and health <u>not</u> equated with number of beds
- Provider-level-algorithms
- Mammoth reduction in the number of health care professionals
- Encourage traditional ways of doing → discourage innovations
- Allow things to happen quicker → more flexible, fluid
- Aware of the limitations of evidence → looking for alternatives to enhance not replace EBDM
- Danger of losing values of current culture, i.e. people factor
- Role of patient preference and choice - question the value of
- EBDM allows government and management people to make better decisions
- Could ignore how you got there
- May result in total focus on ends without looking at means:
- Consideration for other sectoral policy health impacts
- Shift in legal → from precedence-based to evidence-based
- Shift in funding allocations from health to other ministries
- Difficult process to implement
  - ↪ much resistance
- Now, different power brokers → gap between those that have information and those that don't
- It could be harder to criticize:
- Debates among politicians would become evidence-based

- Micro-level → information would be more user-friendly
- Some upward synthesis available for aboveThemes

1. Inter-sectoral cooperation
2. Access to information
   ↪ user awareness
3. Generation of information
   ↪ research, evidence, outcomes
4. Change process
   ↪ consumer awareness
5. Assumed enhanced outcome(s) ?
6. Resource allocation

Discussion of Key Messages Associated with Themes

1. Inter-sectoral Cooperation

a) Absolutely essential that there be Inter-sectoral cooperation across all jurisdictions → federal, provincial, municipal, professional, community, occupational, public.
b) Working towards a common vision / goal utilizing common language.

2. Access to Information

a) All parties respect all ways of knowing.
b) Culture of EBDM embraces the needs for diversity in presentation of evidence.
c) The culture of information is open, accessible, understandable and transparent.

3. Generation of Information

a) Information must be understandable by ALL and encompass both the descriptive and statistical.
b) Information generation is an accepted and integral part of the health system (systematic).
c) There is consistency, comparability - both process and outcomes - in evidence available and used across populations - "apples to apples". Validation and synthesis methodologies are culturally sensitive to the respective populations.
d) Information generation needs to be all-inclusive, not only in the hands of the few.
e) Creation of new methodologies which create a better link between information generation and information use.

4. Change Process

a) Major education is required at all levels
b) Fear loss of . . . .
   - employment
   - profession - health professionals
   - control - physicians

c) Requires . . .
   - inclusion
   - human resources valued → resources included in change strategies

d) Focus on collective interests, not individual.
e) Include illness as piece of health.
f) What is health ? - define.

5. Change in Information

a) There will be a greater transparency in the system for disclosure.

b) There will be a shift of power from status to information.
c) Institutional, cultural, legal, and resource factors will have a role to play.

6. Assume Enhanced Outcomes

a) As the shift occurs towards EBDM, recognize the limitations of EBDM, not a panacea.

7. Resource Allocation

a) Move towards sharing resources across traditional boundaries.

Question 8.1: What is Evidence?

Key Messages

a) What are the criteria which constitutes "good" evidence?

- valid traditional research tools
- experiential → takes experience into account
- clearly articulated assumptions
- valid - relevant and accurate
- must be measurable
- results can be directly linked to the action and / or by association
- evidence is not always evidence
- evidence is clearly articulated and understandable
- evidence is repeatable
- quantitative and qualitative
- evidence should be unbiased
- evidence should be accompanied by its limitations
- trends observations
- can gather evidence outside of clinical trials / randomly controlled
- classification of evidence, weighted, taking into account method of collection
- strive to improve the quality of evidence
- build models / frameworks that ensure we value non-traditional sources of evidence or previous sources of evidence
- distinction between information and evidence
- when does information become evidence?
- important aspect of evidence → applying it at the right time and place / situation
- evidence becomes information when it is used
- evidence is one tool used in making decisions

Question 8.2

- New technologies need to go to trial as early as possible
- Cost-benefit of new technology should be considered
- Broader definition of "cost" → not just money
- Quality of life assessment important
- Special situations where the alternative is death - experimental approaches should be considered
- New policies / structures need to be evaluated prior to implementation

Question 8.3

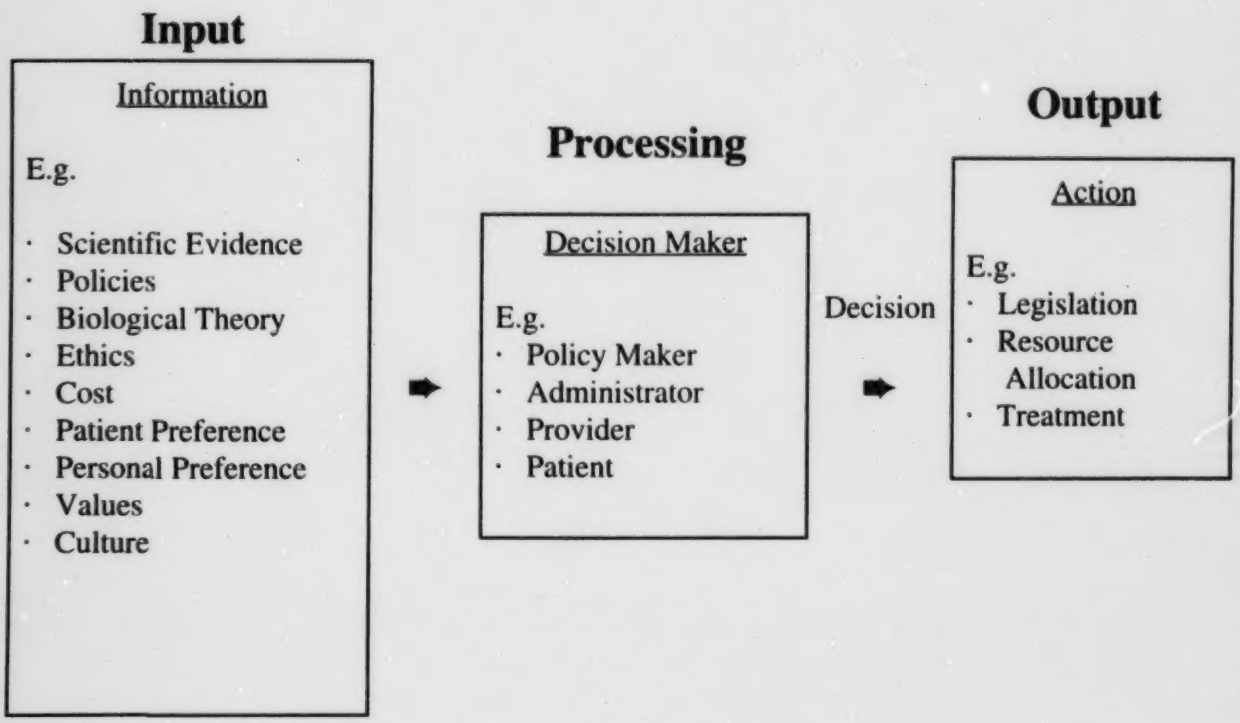
- "Truth is truth"
- How to quantify spirituality?
- Evaluation of health methodologies from various cultures needs to reflect their values
- Regulation is desirable, particularly where potentially harmful
- Are there ways other than regulation to prevent harmful practices / policies

Question 8.4

Part 1: Decide for Themselves

a) Everyone should be able to decide for themselves how to meet their own health needs
b) We cannot categorically say no to new treatments and therapies / non-western and be objectively evaluated
c) Fairness needs to be ensured - issue is very complex

Information-Based Decision Making



Group 10
Questions: 7-8-9
Saturday, April 20, 1996

Culture of Evidence Based Decision Making (EBDM)

- System would run on computers - how you design this would be difficult
  - → e.g. smoking
- Definition of EBDM should include personal settings information - needs to be transparent, so that it can be widely understood
  - → e.g. fluoridation - there was a lot of controversy despite evidence - how do you get acceptance that evidence is worth acting on
- Quality of life issues - e.g. smoking - I have some control of it versus other factors - decisions based on personal relevance

Question 7

- Evidence:
  - → varied and multiple levels - more than RCT's
- Evidence (includes both health and health care):
  - → what is the level of evidence available for a given situation / context?
  - → also have to look at value of result of evidence - e.g. assessing a drug therapy versus a surgical treatment
- Evidence:
  - → open to interpretation
  - → barrier to the use of evidence
- Health versus Health Care:
  - → where do we get the most bang for the buck?
  - → how do you compare the evidence?
- Evidence: values, culture can be included in EBDM
- Does the culture precede evidence, or does evidence precede culture?
- Greater onus of ministries to prove that changes are being made on basis of evidence
- Clinical and personal decisions, greater acceptance to make decisions on basis of evidence versus culture in policy / government
- Poor evidence currently available on costs
- New culture of EBDM needs to be applied broadly and include administration and management of the health care system
- Currently we commit, decide, learn → process
- Culture needs to include values and evidence in both health and health care
- Values - how much weight you give to evidence
- Harmonizing values and evidence
- Resistance to evidence - because it doesn't include "soft" issues
- New culture - at all levels of decision making, parties are explicit about how they made decisions - (so they can be understood, discussed, challenged)
- Research funding to be broadened - in terms of the range of research

- Culture today seems to be cost-effectiveness - leading to a more pragmatic analytical evidence base
- New culture of EBDM includes emphasis on financial issues, government fiscal targets
- Today, people are confused by what they're "getting" in the health system - need a broad range of information
- Should we open up the status quo and broaden people's choices
- Need tools for making decisions
- New culture would facilitate empowerment
- All the evidence doesn't always exist - still the need to move forward on decisions
- New culture includes demonstration of decision makers of their abilities - need to be explicit in decision making - attitude and accountability
- Moving away from individual physician autonomy to autonomy of medicines versus individual physicians
- Patient / individual - empowerment within boundaries
- What should we be doing where there is no evidence? Or where practice isn't changing?
- How do we change?
- Break down silos and turfs
- Need to better understand how public gets their information (e.g. television) to disseminate information better and more broadly
- Need to involve consumers / people in decision - making need to collaborate, communicate and partner
- How do we influence behaviour in areas such as smoking and alcohol - where the evidence exists
- Making decisions on the basis of who they trust
- Determinants of Health issues, e.g. environment - are being glossed over
- Too much focus on the "end stage" - need evidence on Determinants of Health brought to the public for them to debate
- Even with the evidence, it's still difficult to change behaviour - it's not clear that everyone wants to be healthy
- Issue of "trustworthiness" of the messenger
- Leadership, support, community - need these components to facilitate implementation of EBDM
- Importance of dissemination and promotion of evidence
- Decision making and dissemination - are they separate processes? ?

Key Messages - Question 7

- Decisions based on evidence
- Evidence are open to interpretation
- Interpretation is personal and ultimate decision may vary with culture of the day
- Health and health care - need to divide them out
- Varying and multiple levels and kinds of evidence
- People are making decisions on basis of belief systems (fear, values, turf, resistance to change)
- Evidence may be imbalanced - need a more balanced evidence approach (including both amount and appropriateness of evidence)
- Evidence - will never get rid of interpretation - it's a part of decision making
- Making decisions explicit, making information understandable and accessible
- Current focus on economics / fiscal realty may be determining the evidence we're collecting now, but it shouldn't be the only focus

Question 8

- Issues of empowerment and scope of decision making - to what extent is there personal choice?
- Issue of personal accountability
- Raising consciousness and education re: wellness
- Access to treatments - a societal issue
  - → e.g. expensive and not sure of effectiveness
  - → e.g. consumer health information - giving people the information re: options andservices available
- Fostering empowerment, separate issue than the choices people want / have access to
- Range of evidence
- Evidence is information interpreted through a theory
- Population health - reflect socio-economic factors in evidence collection
- Need evidence on sub-populations
  - → e.g. drug testing of women and men
- Need to be careful of bias in RCT's
- Search for evidence depends on values and hypothesis
- Whole range of evidence - needs to be examined in context of decision makers
- Values of patients - this factor needs to be incorporated
- Need to evaluate evidence in a multicultural society
- Evaluate outcomes, to treatments - need to clarify what are the desired outcomes
- What is evidence for whom?
- Individual as patient, consumer, and providing input into policy making
- What do people use to make informed decisions
  - → e.g. meta-analysis of RCT's, case reports, provider experience
- Is there a preset scale that is reliable?
- Evidence - best available information upon which to make decisions
- Hierarchy of level and kinds
- Using different types of evidence, depending on circumstances and issues being examined
- How does evidence fit into spirituality
- Need new indicators in areas of primary care and primary health care
- Evidence needs for national health policy
- Who's objectivity?
- Sources of reasons:
  - personal experience
  - cultural traditions
  - respected peers
  - events / trends over time
  - research findings - statistics
    - experimental
  - intuition
  - values
  - media
  - desires
  - traditions (professional)
  - successful outcomes
  - anecdotes

- habit
- mother's medical history

Question 8.2

- There will always be new technologies - once there is more agreement on values, we can better assess new technologies

Question 8.3

- Apply higher standards to new interventions - we treat non-western medicine as new technology
- We need to foster collaboration on examining principles of non-western therapies
- Opportunities to learn from non-western medicine, but they need to be evaluated

Question 8.3 and 8.4

- Will doctors feel comfortable referring patients to non-traditional therapies??
- Standards have been changing - what's the baseline?
- Standards of evidence - i.e. different culture standards - what will we fund?
- Standard - greatest good for largest numbers
- We can learn a lot from other standards of care and prevention
- Are we going to adapt things to current model or develop a new one?

Question 8.5

- Set a standard and fund treatments accordingly or examine principles and see whether they fit within western morals
- Standard as efficacy versus cost

Question 9: Access

- National information standards
- Broad-based multi-sectoral
- Person-oriented birth to death
- Easily available, but also respecting confidentiality
- Population-based, linked to personal
- Outcome analysis
- Comparable
- Affordable
- Funding an issue

- Health indicators
- Assess reforms / structural improvements
- Aggregate different ways
- Need the technology
- Quality
- Types of information:
    - linked to database systems
    - cost / benefit data
    - explanation of terms, concepts, explanatory appendix
    - consumers - basic information of condition, and likely progression of condition (information they can assess, tailored to their cultural needs) - user friendly

Question 9.3

- Timely information
- Communication link between provinces, individuals
- Good data interfaces
    - → confidentiality
- Circulating information about without identifiers
- Sustaining a national health survey

Question 9.4 - Accessible Information

- Have document information as part of administrative system
- Using administrative systems to support health promotion education
- Do they want to be equal partners?
- Clarify role and tailor information - it's a difficult role for providers to do

Key Messages

- Personal factors affect whether information is accepted as evidence and will affect the relative weight given to evidence
- We want a standard that everyone agrees to; answer varies depending on circumstances
- Focus on evidence for national policy - on efficacy and value for $
- The need to question convention of levels / standards of evidence
- More evidence than scientific evidence, and they're subject to different standards
- Need to consider incorporating non-traditional therapies if effective
- Need to apply same standards to western medicine as we expect from non-traditional medicine
- Process to decide evidence standards by which to decide national standards of practice
- National person-oriented, confidential, accessible, integration, cross-sectoral
- Consistent evaluative process, whether established western medicine or introduction of new western medicine and non-western medicine

Group 11
Questions: 10, 11, 12, 13
Saturday, April 20, 1996

Question 10: Values With Respect To "Health"

Most Important		Least Important
	1. Efficiency	
③	2. Comprehensiveness	
	3. Quality of care	
	4. Patient autonomy	②
②	5. Equal access for individuals	
	6. Equitable shares for groups	④
	7. Neediest first	③
	8. Maximum benefit for dollar	①
①	9. Healthy population	
	10. Societal integrity	
	11. Accountability	
	12. Responsibility	
	13. Recognizing the limits to practical resources	
	14. How / when do you measure "maximum benefit for dollar"	
④	15. Individual responsibility for health "patient autonomy"	
	16. Minimization of harm	
	17. Quality of what you do - access to good information	

Proposed deletions from values list: - Nil

Conflicts in Values

1. The broader definition of patient autonomy needs to be drastically revised to reflect the need for individual responsibility
2. Inherent tension between societal responsibility and individual responsibility
3. Equitable shares for groups may be a function of defining the ability of individuals to meet their own needs
4. "Bang-for-the-buck value" / the constraints need to be acknowledged

Question 10: Values - Message

1. "Why are some people healthy and others not?" These values do not relate well to this question. (Refers to Values question #10, numbers 1 through 9)
2. Question requires additional thought to articulate the values
3. Does individual versus societal responsibility relate to "service providers"?
4. * They are all Value Statements which are recognized (* Values #'s 1-9)

5. Forum needs to articulate how Values will affect decision making - so that members of the public will understand

Values With Regards To "Health Care"

Most Important		Least Important
①	1. Efficiency	
②	2. Comprehensiveness	
	3. Quality of care	
	4. Patient Autonomy	②
	5. (a) Equal access for individuals	
③	(b) Equitable access for individuals	
	6. Equitable shares for groups	①
	7. Neediest first	③
	8. Maximum benefit for dollar	
	9. Healthy population	
	10. Individual responsibility (relates to exercise to patient autonomy Value #4)	
	11. Care giver fidelity to the whole system - client needs, as well as systems needs and health needs	
	12. System must benefit the human / humanity	

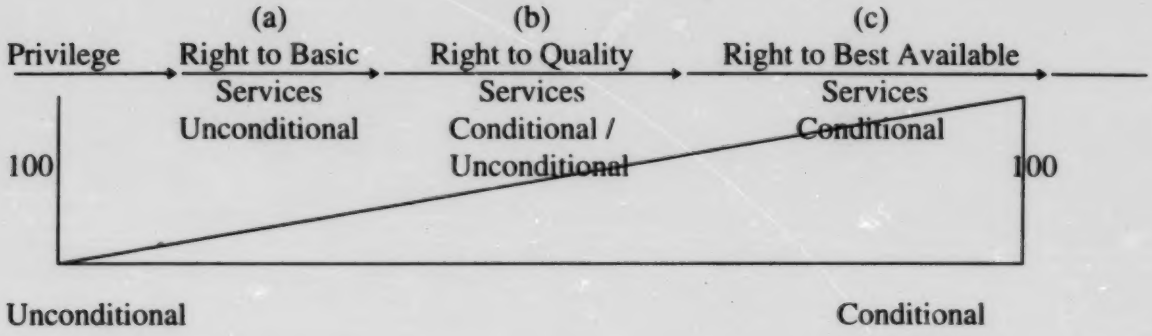
Comments Re: Values - Health Care

1. Need to distinguish not only between health / health care, but also what is chronic health care/ emergency health care, etc.
2. Number 5 "equal" access should be "equitable"? (access without financial impediment) Need to clarify / differentiate between "equal and equitable".

Conflicts in Health Care Values

1. Comprehensiveness
   - → so broad - undefined (comments on definition issue)
   - → hard to get agreement on the application of the values
2. Healthy Population
   - → much more important in "health" values context than on "health care" context

Continuum - Right to Health Services



Note: the priorities for this group fall equally between Right to Quality Services and Right to Best Available Services

Right to Health Care Continuum:

1. Group Definition:
   a) Survival - right to service
   b) Quality - required level of service
   c) "Cadillac"
2. Minimum - Optimal - Maximum
   ⇝ as a measure (to define)
3. As a society our values have moved beyond "basic" services
4. Conditional RightversusUnconditional Right
5. Availability and access affect all aspects of the continuum
6. Need to clearly identify, define what is:
   ⇝ conditional
   ⇝ unconditional

Message

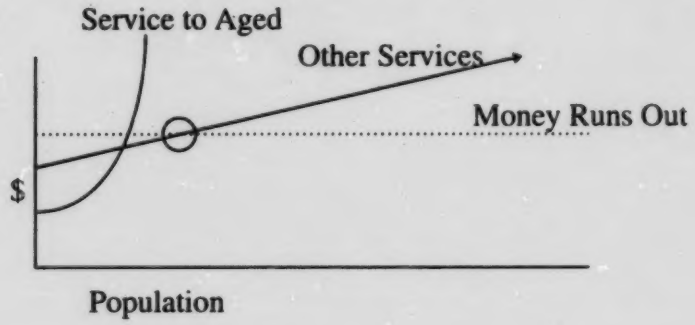
- Group identified that on a continuum, the right to health service is at the "quality" and right to best service end of the scale.
- The Forum must define terms such as:
  - basic services
  - quality services
  - best available service
  - conditional services
  - unconditional services

  to make them meaningful and useful

Health Policy

Meets Need of Sick and Vulnerable ⟷ Improve Overall Health and Quality of Life

1. If dealing with one, "Meet Needs of Sick and Vulnerable", are you not dealing with all → "Improve Overall Health and Quality of Life".
2. Must figure out best balance and allocation between meeting needs and improving overall health and quality of life.
3. Must determine where the tradeoff should be when related to $'s versus service
4. Must acknowledge and articulate what tradeoffs are for public understanding



- In determining tradeoffs - need public consultation

Question 12: Criteria for Prioritizing Waiting List for Services

1. Medical urgency
2. Benefit to the individual
3. Benefit to society
4. Age
5. Lifestyle factors
6. First come first served

Additions

- Opportunities for learning
- Opportunities for research
- Readdress past "wrongs" (may be examples of benefit to society)

Deletion

- First come first served should not be a criteria

Comments re: Criteria for Prioritizing Waiting List for Services

1. In prioritizing, priority list must relate to rights to service continuum / criteria
2. Quality research can be used to provide prioritizing services
3. As with earlier lists of criteria, e.g. "Right to Health Care", the "Waiting List" criteria must be defined and articulated for public understanding
4. Consider the criteria as a package, not in isolation
5. Given the appropriate information on choice, e.g. life style, and understand the implications, then must accept consequences of individual decision

- Discussion was around acute care only - and still needs full discussion on other areas

Message

- Concern that we did not discuss the "two-tier" system issue vis a vis values
- Implicit in discussion on continuum of services, even "rationing" of services is based on a one-tier system

Question 13: Inequalities / Resources for "Health"

Comments

1. Society has disproportional investment in health care and ought to invest more in determinants of health, i.e. education, nutrition. (Some members disputed this point - not full acceptance)
2. Health system should be expanded to include some services which are preventative
3. A value - there ought to be "a right to the pursuit of health" - hence society needs to make some investment so individuals can make that choice

Group 12
Questions: 10, 11, 12, 13
Saturday, April 20, 1996

Question 10: Values - Assessment of Relative Weight

Priority Votes

	· Efficiency: (bang-for-buck)
✓	· Comprehensiveness
✓✓✓✓	· Quality of care
✓	· Patient autonomy / provider autonomy → autonomy of the person
✓✓✓✓✓	· Equal access for individuals
✓✓	· Equitable shares for groups
✓✓✓	· Neediest first
✓	· Maximum benefit for $
✓✓✓✓✓✓✓ ✓✓✓✓✓	· A health population, healthy communities

Additional Values

	· Openness
✓✓	· Individual, personal responsibility
✓✓	· Quality of life
✓✓	· Dignity and well being of all individuals
✓✓✓✓	· Public participation
✓✓✓✓	· Respect for traditional healing values - (First Nations)

Question 11

- How do we define a '<u>right</u>' to health care?
- Rights, expectations
- Rights to public health, as regards to 'health', broadly defined
- "<u>Duty to provide</u>" - to be distinguished from 'right'
- Individual, collective rights
- Mutual aid - many partners

Note: Personal responsibility is involved when discussing rights

Conflicts

- Equal access
- Conflict of / inequity - urban versus rural
- How do we define <u>health</u>?
- Integration of medical community

Question 12: Allocation of Resources

- Within whole system providers
- Need
- Where to place emphasis?
- Improve criteria as to how we allocate resources - re-balancing
- What basis ? - evidence, politics, 'to feel good'
- Decisions to be in hands of community
- Health needs assessment as one basis for allocation
- Look to elements of community health
- Equal proportions within healthy community; integration
- All elements should work together to sustain and support - moneys to sustain health - one "Pot"
- $ Pot $ → criteria ? = health community
- Re-invent ourselves
- What do most Canadians want? 99% $ to hospitals / doctors?
- Limited resources - where do they go and on what basis?
- Public participation - values influencing allocation decisions
- Caution with community-based needs assessment
- Limitations on values as basis of resource allocation decisions
- If we increase $'s to prevention / promotion (wider determinants) how active / passive Ö interventionist would we be?
- Improving public's mind set around health → cause and effect education
- Public buy-in required
- Should distinguish between allocation within health care sector and re-allocation to other sectors
- Is there societal consensus on values? - difference in values resulting in action on issues
- Clarifying values at the community level - critical
- Basis for decision making - allocation:
    1. Evidence - evidentiary basis
    2. Public pressure - community input / values
    3. Intuition - beliefs / values
    4. Consequence: "if we don't act . . . "
    5. Tradition - it has always been done that way
- Allocation Priorities:
    - $'s to primary care, prevention (poverty - children)
    - Hospital and medical care that is sustainable
    - Home care - wellness
    - Education - literary
    - Housing
    - Employment
    - Environment
- Grass roots needs assessment - community-based evaluation of effectiveness to be built in
- Existing allocation within education, social services, etc. are not done effectively
- Fix existing 'Pots' before proceeding
- Existing <u>waste</u> within health care system
- Increase allocation to children - child health; expand
- Gender influence on allocation decisions;

    → allocation decisions depend on asking the <u>right question</u> - critical when addressing allocation of resources

- Remove existing "stove pipes"
- Communication / understanding - building and starting dialogue
- Re-allocation within the health care budget
  ⇒Target problem areas:
    - pharmaceuticals - drugs
    - abuse of system
- Evidence varies , note: how to define; (definitional issues)
  ⇀ (some jurisdictions include Housing, Corrections, etc. in definition of health care)
- Slave to empirical basis
- Evidence needed when increasingly moving from institutional to community care
- Acute care decreasing cuts; community "care" to pick up - providing evidence / appropriateness
- Health services to meet needs
- 60's - "Medicare" - created myth re: hospitals / doctors - medical model
- Talk of evidence-based decision making to be coupled with an evaluative mechanism - evaluation at the outset

Canadian (= healthiest people) health care envy of many countries - not to be lost

Question 13

- Those who know health care system - or people in it - have different access, therefore, inequalities
- Health care services unevenly distributed - north versus south, access - inequalities
- Facilities, geography, cost issues all factor in north / south inequalities
- Concern of move to two-tier public / private health care system
- Unable to correct existing inequalities if we move to two-tier
- Access - issues
    - urban / rural
    - provider roles ⇀ funding
    - diversity of services
      ⇀ teaching versus non-teaching hospital environments
    - public - private
    - waiting list variation
- Universal access - how to define in these times; core versus essential / fundamental services
- To keep it universal, we have to examine what we mean by core and fundamental
- Uniqueness of 'northern' issues / from urban-rural
- Two-tier would have negative impact on:
  ⇀ quality of health care
  ⇀ research
  ⇀ training
- Health very personal is different from other material goods - commodities
- Now it is two-tier; increased privatization would lead to three-tier system
- Universal access to health <u>outcomes</u>, rather than services
- Public / universal health care system defining feature of Canadian citizenship - core value
- Are we, as Canadians, moving towards the public question of accepting two-tier health care systems?
- Exodus of Canadians and knowledge to U.S.
- How one views two-tier Canada depends on individual perspective / circumstances
- Two-tier leading to 'cream skimming'
- Two-three tiers unlikely to address "northern" inequalities

- The issue is not money $ but core values of we as Canadians
- With respect to our health, the health care system to be viewed as last resort, not first resort
- We have no public policy that rewards healthy lifestyles / increase accountability

Group 1
Sunday, April 21, 1996

1. Review / Synthesis of Saturday Discussions

What is your personal synthesis of what you heard and experienced in the context of the health system?

- Varying perspectives and interests provide value and contribute to discussions
- Why haven't we made progress - understand history to make progress
- Action - real recommendations
- Times have changed - rhetoric the same - do something
- Improvement is necessary to preserve system
- Principles as base - but "implement" changing approach
- More trust for action
- Readiness to partner
- Common goals
- Buy-in with respect to health versus health care - improve health of Canadians
- Feds should focus on health of Canadians
- People working in system willing to change
- Agreement on list of values but not real consensus on trade-offs across values - ambiguous definition - conceptual level only
- Need to improve infrastructure
    - evidence
    - information
- EBDM - should apply at political level
- Recent changes not evidence-based
- No evaluation framework in place
- No accountability structures
- Using less EBDM at meso level

2. Key Messages and Key Issues

Given the key messages, issues and ideas which emerged from the theme area discussions, what do you see as important implications and impacts at the <u>health system level</u> i.e. Issues Forum to address

- EBDM - will take work and $'s and political will - needs buy-in
- Definitions common understanding of key terms / concepts needs e.g. define health / health care / necessary care
- Determinants - choose priorities - goals - what we measure. Forum must be clear- measurable indicators.
- Need benchmarks
    - outside system
    - within system
- Need standardized information for EBDM
    - coordination / integration
    - consistency
    - interpretation / use
- Set measurable targets over long-term related to major health problems (like Quebec paper)
- Have to look at policies / programs for consistency with health determinants and overall health objective (actions not consistent with health objectives)

- Caution in defining determinants of health
  - social
  - medical / wellness

  } models
- F / P / T to do impact analysis on health for all policies / program reductions
- F / P / T - duplication, reduce barriers
  - share information
  - standardization
- General advice to F / P / T ineffective - be specific and realistic - identify activities that could be done - how to do given F / P / T - specific / tangible / feasible
- Can we achieve common formulary at national level?
  - Need political will
  - Use partners
  - Identify barriers and establish strategy to overcome
- Formulary may not impact on health of Canadians - when other determinants more notable e.g. child poverty (affects cost and quality of care)
- Lots of potential priorities
  - how do you choose?
  - Forum can develop strategy to help
- F / P / T initiatives - pick from input
  - something doable
- Also, long-term wish list
- Concrete action plan
- F / P / T structures weak - where can we:
  - agree on priorities
  - allocate resources
- Need to invest in education around values
  - health and health care
  - can have changes in health care system that shift to health system and improve health
- CIHI is good start with problems (4/5 on 10 scale)
- Need for bridge / transition funding - particularly as shift to community-based care occurs - have to be in place before improvement occurs
- Improvement requires investment
  - may have bigger mess in SR

3. New Creative Thinking

What are some new ideas, emerging issues or creative notions that should be considered by the Forum?

- Looking at long term plan
  - promotion / prevention
- Encourage multi-skilled workforce
- Look at value-added to client - part for organizations
- Address work force issues / concerns
  - de-skilling
  - multi-skilling
  - national dialogue
  - de-valuing
- Empower clients
  - vouchers

- choice
- Private sector partners
  - capital
  - overlook opportunities
- Evaluate MD-driven system - is it good?
  - Type level of care provided
- Evidence-based research - re: what skills / certifications are needed for certain tasks
- Do we need all the professional bodies / certification bodies? (may go down)
- Need planning for health care resources - other than MD's
- What about paying families for support
  - low pay
  - risks of injury
- Role of health centres providing "acute-care"
- Put effective F / P / T structure in place
  - research
  - work on real issues
  - information
  - real partnership
- If MD's are going to be gate-keepers - need to educate consumers
- Role of private sector - must be partnership - not total control
  - be fair
- Multi-skilling and competency
- F / P / T standards on quality of services
- Consistency organization structures at provincial and federal levels
  - (i.e. Department of Health and Community Services not just Health)
- Collaboration between public / private / providers
  - not all bad / all good

4. Final Thoughts - Advice to the Forum

- Job is not finished when report comes in
- Need effective F / P / T structure
  - real responsibilities
  - reflect national priorities
  - allocate resources
- Good written plan of action
- Leave something that lives on - can be used by others - deliverables
- Business plan
  - timelines
  - cost
- Forum could continue
  - someone must take ownership
- Members take recommendations with them
- Legacy - Canada Health Act broadened to community-based activity
- Forum influence politician's decision
- Clarify key terms / concepts
- Healthy public policy emphasized - beyond health care

Group 2
Sunday, April 21, 1996

1. **Review / Synthesis of Saturday Discussions**

- Upbeat - a lot of consensus for principles, comprehensiveness - some concern
- Plain language
- Positive sense
- Concern - how Forum can lead - in view of current activities
- Wrap-up (Group 6) - weak
    - ensure all information is captured
- Fun
- Process - (conclusion)
    - too complex - difficult to put in context and draw conclusions
- Good opportunity to see things - but not developed

2. **"Given the key messages, issues and ideas which emerged from the theme area discussion yesterday, what do you see as important implications and impacts at the "system" level?"**

- Selling messages to provinces - themes for decision making
- Communication of ideas, messages - translation to next levels
- Standards - how will they be maintained public / private sectors
- Implementation - barriers, action on barriers - consumers need more involvement for movement
- Myths - where is decision making
- Lack of focus on what to apply it to
- Government financing "tinkers" - underpinning for health
- Silos - Canada Health Act - not meeting needs
- Allocation - huge problem bottom line - federal government lost lot of control - transfer huge problem
- Serious reservations about federal government policies and impact on social programs
- Challenge - limits to social spending
- Concern - poverty of children
- Short term decision making
- Need clear vision on health - look at social programs
- Cycle of spinning with emphasis on evidence and consultation
- "Health is a political construct"
- Information - doesn't of itself turn things around . . . analyze barriers
- Identifying biases and counter-acting - coming to consensus
- Socio-economic equity s health - policies don't match
- Healthy population concept has to be put into action
- How do we do it?
- Public understanding - how to achieve
- What do we want government to do
- Debate, not just in health care - how to move debate
- Balancing - debates inside and out
- Values
- Health status - in fact going backwards - social net reduced
- Political change happens in bite-size chunks

3. Creative New Thinking

- Integrating
- Assessing information - research

4.Final Thoughts - Advice to the Forum

- Cost of drugs - thorough review of C91 . . . analysis of impact
- Maintaining principles of Medicare
    - no two-tier efficiencies
- Expand to include home care . . . - integration
- Renewal of Canada Health Act to pull together national framework to widen
- Address barriers to reform
- Communicating to people
    - really listen to people
    - mismanagement and waste need to be addressed local level
- Equality versus equity targeting resources s equity
- Tangible steps
    - mechanism free of "political" group responsible for defining common solid basis to Medicare
- National vision statement - stop fragmentation (provinces) until clear assessment
- Keep health and health care separate
- Preserve wisdom stewardship - responsibility - "apolitical body"?
- National council on health (with consumer membership)

Group 3
Sunday, April 21, 1996

1. Review / Synthesis of Saturday Discussions

1. Creating a "system" rather than associations of "competing interests"
   - ↪ clear objectives
   - ↪ "regionalization" problematic
2. Put teeth into how to make politically accepted and implemented
   - ↪ i.e. Forum address the politics of health care
   - ↪ recommendations → strategy
3. Role of federal government in leadership within decentralizing system
   - ↪ principles and guidelines tied to funding
   - ↪ setting national goals for health
   - ↪ keep dialogue going among competing interests re: common problems (role of body independent of Health Canada)
4. Canada Health Act
   - ↪ given fiscal situation, potential for two-tier / privatization, how to address issue of access among poor, regional, cultural, urban / rural
     - e.g. overcoming problems of service delivery and allocation, resources, access to certain other services (e.g. psychological)
5. Centralization of resources
   - centralizing in largest centres
     - ↪ travel costs / time
     - ↪ family support
     - ↪ financial support
6. Strengthening national organizations
   - continuing to strengthen expert groups
     Forum identify which national groups already have good organizations and endorse as national bodies worthy of maintenance
7. Balancing "health" and "health care"
   - danger that focus on "health" may undermine much of infrastructure of "health care" system
     - ↪ when reallocating resources within system, need to look beyond health system
     - ↪ need to involve groups involved in "population health"
     - ↪ public health
     - ↪ NGO's
     - ↪ public works
     - ↪ volunteer base
     - ↪ need greater balance within health care system itself
     - – e.g. · move up from 4-5% for health promotion
       · greater good for greater number
       · coverage
       · home support
       · drugs outside hospitals
8. Volunteer base within system
   - ↪ forcing volunteers out of roles in system
     - may not be coming in elsewhere

9. "Comprehensiveness"
    - ↪ need to define and put teeth into it to give it national meaning
    - ↪ what need not be included / covered in public system can be passed to private sector
10. Federal versus provincial roles in developing "national" system
    - ↪ assume federal government will shape "national" system
        - issue may be how to get provinces to buy-in to create national system from bottom up
        - putting more teeth into Canada Health Act principles and addressing tensions over who has the "final say"
        - future "Forum" requires provincial buy-in
        - "Forum" role in evaluation of major shifts
11. Making "Advisory Councils" work effectively
    - multi-sectoral approach
12. Preserving national system
    - worry about "buzz words"
    - expanding population health
        - ↪ education
    - too much strain on health care system to do everything

2. Emerging Issues / Creative Approaches: Identifying the gaps and linkages and deliverables

1. If move to evidence-based decisions, must have "clean data"
    - ↪ build system to provide
        - record usage in ways comparable across jurisdictions
        - make data and analysis available
        - identify what is in place currently
2. Have clear national health goals
    - ↪ set targets for health status
    - ↪ clear national health indicators
    - ↪ link to databases
3. Create culture for clinically-based research
4. "Renew the Canada Health Act"
    - ↪ include concepts of "population health"
    - ↪ access to health system
    - ↪ redefine "comprehensiveness"
    - ↪ clarify limitations
5. Determine the "gatekeepers" of the health-driven system
   criteria:
    - ↪ advanced clinical skills
    - ↪ advanced training
    - ↪ one of family of regulated health professionals (i.e. accountability)
        - ▸ not necessarily a physician
    - ↪ able to handle diverse entry points
    - ↪ able to use innovative technology
6. Address relations and issues between health care system and pharmaceutical industry (Bill C-91)
    - ↪ evidence
    - ↪ utilization

3. Final Thoughts - Advice to the Forum

- Make a system (it won't be a simple or clean process)
- Continue the process of expanding "health care" into "health"
- Breakdown the stovepipes and create the multi-sectoral approach
- Create reliable and valid information
- Create national health goals
- Provide funding tied to national health goals
- Recognize provincial interests, while recognizing that Canadians still look to federal government for leadership, standards and guidelines
- Invest as well as restructure
- Recognize health and health care as still central to political mandate and central to Canadian identity
- Proceed to privatization with extreme caution and with a plan
- Continue to consult with people about what they want in their health care system

Group 4
Sunday, April 21, 1996

1. Review / Synthesis of Saturday Discussions

- Five Canada Health Act principles need to be maintained
  - → but what do they mean today?
- No change for the sake of change (if it ain't broke, don't fix it)
- Change should be based on solid evidence
- Importance of inter-sectoral collaboration between ministries (including finance, human resources)
- Values → healthy population is most important value / health of individuals also important
- Within population-health approach, important to consider equity
- Re: evidence → can't always wait to have "solid" evidence before acting
- Values - need more discussion
- Re: public / private → if cuts to public system continue, need to leave / define role for private financing
- Private expenditures are increasing
- Public expenditures are decreasing

  } Cost shifting by Feds

  - → need to get some services back under public umbrella
  - → Canada Health Act is starting point
- Re: private / public markets
  - → think carefully before "importing" models
  - → two-tier concern re: home care and LTC
- Dilemma between pharmacology and health costs
  - → Bill C-91

2. Key Messages

- Review / redefine Canada Health Act principles
- Review C-91
- Strengthen PMPRB
- Review drug marketing strategy
- Incorporate department of health in decisions about health and health care
- Minister has role to educate public and has obligation to <u>listen</u> to Canadians
- Examine accessibility to quality health care

3. New Thinking

- Stronger mechanisms for inter-departmental collaboration (federal / provincial / local / other sectors)
- Harmonization of drug formularies and drug distribution system
- Make health and social transfers more needs-based (as opposed to per capita)
- Make sure move to community-based care respects "humanity" element
- Increase research on population health, but not at expense of basic research
  - → create research consortia
- Need to reward individuals for healthy choices

- Find mechanism to incorporate community values in setting research priorities
- Need to undertake and promote research on alternative medicine, e.g. acupuncture
  - ↪ impact on health and social aspects
- Endorse Vancouver Institute for Complementary and Alternative Medicine
- Educate Minister that improvements in quality of care are not necessarily cheaper - can't continue indefinitely to cut funding
- Need to re-empower doctors to recognize contribution of complementary medicine
- Expanded role for Feds. to assess the need for health professionals in 21st century (workforce planning)

4. Final Thoughts - Advice to the Forum

- Strengthen capacity of communities to accept responsibility for taking action on health
- Minister's first audience is Minister of Finance re: non-negotiability of Canada Health Act principles
- Don't make a change in one part of system before analyzing impact of that change on other areas of the system (e.g. home care in Manitoba)
- Articulation of values is key if we want to maintain Canada Health Act principles
- Minister of Health needs to identify / define Canada Health Act standards and identify how they will be enforced
- Balance human element with technology → always keep consumer in mind
- Information system is needed to provide consistent, reliable information for decision-making
- Reinforce federal role re: marketing / approval, provincial role re: usage

1) Favour lumping or de-lumping CHST ?

De-lumping	✓
Lumping	✓✓✓(put community input into proportions

2) Favour additional health tax for health and health care

Favour	✓✓✓*
Not favour	

*On condition that there would be a link to new services and broader health interventions

- Do more research on the health of women
- Amalgamate ministries of health and social services
- Explore possibility of making health a taxable benefit
- Need more research re: balance between health, education and social services
- Need to promote "effective citizenship
  Re: CHST → link sources to uses, to ensure politicians are accountable
- Required reading → "Life" Before Medicare"
- One wish . . . . . that health reform not be fiscally driven
- Come back to review recommendations
- Come back or at least have the opportunity to review and make final recommendations to Forum
- Some proponents → get on with it
- General principle: consider determinants of health as part of decision-making
- Caveat: federal minister of health has limited responsibilities and authority in health / health care

- Minister of health cannot be solely responsible for population health (key role is to facilitate action)
- Information systems need to incorporate health care and health information (increase from other sectors as well)
- Quality of care
- services must be there to ensure quality care
- Education / participation of public is key: Minister has in important PR role (makes decisions easier for regulatory authorities)
- Need to ensure Minister and Prime Minister are listening
- Minister should re-evaluate and redefine the five Canada Health Act principles (e.g. health care has moved beyond doctors and hospitals) "to what" do principles apply?
- Re: federal role, a national discussion about values would be useful
- Canada Health Act principles are supported across the country, therefore, the Minister should continue to enforce Canada Health Act
- Bottom-up approach to resource allocation between departments
- Need to be consistent in enforcing Canada Health Act principles (e.g. portability and Quebec)
- Role of Health Protection Branch: make sure drugs are only introduced in market after thorough evaluation (timing)
    - re: drug advertising - need guidelines
- Federal Minister should play key role in C-91 review
    - need stronger regulation of new drug prices
    - need to monitor research and connect royalties to research and shorten patentprotection (but may be difficult with NAFTA)
- Public health action re: drugs, tobacco
- Prohibit advertising of drugs

Group 5
Sunday, April 21, 1996

1. Review / Synthesis of Saturday Discussions

- Hesitation to discuss some issues:
  - → ethical questions
  - → what's fair
- Relations between health and social services
- Definition of health care and sickness care
- Re-imbursement system "perverse" - inconsistent with health
- Control of issues with pharmaceuticals
- Passion about cleaning up actions - control in pharmaceutical advertisement and power
- Partnerships problematic for lack of modeling from our field
- Lack of leadership
- System has not recognized need for special cases
- Not throw out current system, lot of good to retain
- Are we taking on too much with health and health care? Should we choose one? Or choose a few "areas"?
- Change is coming: What is the goal?

2. Implications

- What is "optimal"?
- "System" is moving target
- Must factor in other social realities
- Must be able to deal with sickness

3. Messages

1. Policies must include realities: Education
2. Don't use for deficit reduction, keep dollars in system
3. Determinants of health should drive change and be basis for funding
4. Deal with lack of will at the provincial level
5. Look at Green document, "Strategies for Population Health" - Federal / Provincial Ministers of Health, September 1995
6. Change in funding structures; solo practice groups into network;
7. Three pots of funding - mandatory services - exclusions (obstetrics) - fund for higher-risk populations
8. Present the need to change to Canadians, explain it, identify outcomes, publicize, promote
9. Create a national debate on these issues: Health and Health Care
10. Include public participation in decision process
11. Define 'community' and 'community groups' and involve them
12. Need strong national force, presence
13. Recognize that political will is a reality, but don't get immobilized by it
14. Continue national debate
15. Get and use evidence to increase efficiency
16. With respect to disabled people find other ways to provide services out of health care system

17. Use grass roots community development to improve health and health care and promote change at the provincial level
18. Gap in personal service, look at ways to provide them to disabled people (life services - transport . . .)
19. Inclusion of provincial and federal and communities to build dialogue and script for providing services
20. Create a vision for health and health care in Canada, evidence-based, supported and followed
21. Identify new ways to bring services, have models already in place as inspiration for other communities
22. Use finance to look at system structure
23. Change incentives that will cause and / or encourage behaviour change
    - ⇢ practices that keep people healthy
    - ⇢ community activity
    - ⇢ obtain desired outcome from services
24. Develop national piece of legislation to establish health objectives and practices (caution: maintain principles of Canada Health Act)
    IMPORTANT: Must be a joint federal / provincial undertaking

Final Thoughts - Advice to the Forum

- Changes for the greater good
- Evidence is there
- Maintain priority of quality care (level)
- Remove obstacles for disabled senior and native
- Use common sense, don't play politics
- Continue to create opportunities for the Minister's agenda to be heard
- With respect to shareholders, include youth
- Identify what the values are, and priorities
- Use available information out there, and decision support tools
- Focus on incentives, get on with it!
- Actions and incentives consistent with rhetoric
- Health Forum to deal with high level issues of
    1) Values
    2) Funding / remuneration / incentives
    3) System relationships
- Empower those who can change to do it
- Invest in research, health services delivery and healthy community models
- Systematic coordination of above

Group 6
Sunday, April 21, 1996

1. Review / Synthesis of Saturday Discussions

- Crisis in health care financing not caused by social policy - shouldn't bear brunt of decrease
- Make sure community services are in place before closing institutions
- Critiques of current system but is there a better one? - keep working to improve Canada Health Act
- Need consensus on values
- View is health overall - look at broad determinants
- Have discussed health care system, but what are our values and goals re: "health"?
- New thinking is required re: health - beyond health care
- Health care not a "commodity"
- Not much discussion re: implications on human resources / business of health industry
- Decisions re: health and health care should be based on evidence - but no consensus re: what is evidence
- Other factors - cultural expectations
- Impact of changing demographics / not discussed
  - → preparation for older population
- Should have a process to involve all interest groups
- Previous lack of innovative thinking
- Impact of reforms → regulatory level - on health and organization of services - e.g. re: access (principles - Canada Health Act)
- Health care costs not rising except drugs; Canada's expenses on other social services among the lowest internationally)

2. Key Messages

- Change of focus on:
  - → definition of professions and roles - not just physicians
  - → health care → is public, private and alternate (i.e. more than just the public service)
- How turf protection needs to change
- Look at real trends / increase in health expense, i.e. mainly drugs
- Still need to work on definition of "health"
- Flip the system around to focus on health not health care
- Need for mechanism to address turf and create greater understanding among providers
- Need to learn how to communicate - too much talking, not enough listening
- Don't just talk to providers
  - → need to ensure expectations of consumer fits into reality of the system
- Base choices on values and morals
  - → human not economic
  - → get closer to individuals
- Change roles F / P - re: regionalization
- Professional autonomy
- What is the definition of the new reality - what will the $'s allow
  - → how to distribute
  - → who will suffer

↪ make humanitarian and consumer-oriented → professional issues less important
(Don't necessarily endorse / want this - does "can't" mean can't or won't)

- Need for processes for decision-making and cooperation in a multi-disciplinary fashion
  ↪ beyond health → to other sectors
- Base on Canada Health Act principles - but also financing issue

3. Final Thoughts - Advice to the Forum

- Desire to preserve as much of broad system as possible in the face of pressures to cut - system not over-funded → related pressure to move to American (private) model
- If develop better ways to use evidence → lead to more rational use of resources
- Commitment to determinants of health → look intersectorally re: resource allocation
- Who can have influence - appropriate roles of F / P / T governments and regions
- Determinants of health evidence should be used → cyclical
  ↪ walk the talk re: existing evidence
- $'s should be allocated re: proper accounting in the system
- Where privatized → service became more expensive than when volunteer
- Contracting out → drain out of community
- Need to understand leverage (re: financing) at local level → re: national standards
- Competitive markets don't best serve client needs
- Employment security for health workers
- Don't want poor to suffer → services to those who have $'s - health shouldn't be a privilege
- NAFTA - impact / irreversible re: trend to privatize
  ↪ think of larger implications of competition
- 2-Tier system should not be brought into Canada
- If health → determinants of health, need to educate public re: directions
- Deficiency of conference in involving front-line physicians → need to engage broader physician population
- Burden to families re: terminally ill - don't take away "choices"
- Don't spend enough time talking to actual providers and Canadians
- Need to do more re: needs assessment; tap broader community wisdom
- Turf protection still number one
- Remember and recognize large numbers of volunteers (e.g. income tax) - roles
- Pitch for informed community debate - gap between what advocates are saying and views of community
- Determinants of health means responsibility of health plus finance, and other departments
- High risk community needs not always relevant → some simple home grown solutions better
- Health - holistic → multi-disciplinary and involves other sectors
- Caution: re: ability of volunteer sector to pick up "cuts" to formal system
- Corporate sector to welfare state has decreased; look at revenue side as well as cuts
- Potential for volunteers to make system cheaper appealing
  ↪ not necessarily true
- At same time, cuts to agencies that recruit volunteers
- Implications of introduction of unregulated professionals
- Community stories are "evidence" - need to collect
- Needs assessment not at individual level but for community
- Regulatory reforms / decentralization
  ↪ needs to really enhance community involvement (values)

- Keep some power for coordination at federal level and guardian role
- Preserve professional autonomy of physicians and broad roles, best advocate for patient
- Relationship - physician - other providers - patient; key
- Physician will need to practice differently as move to determinants of health
  → need incentives for physicians to participate
- Increased number of professional groups drives costs upward
- Still hear a lot of holding onto professional roles
- No $'s for cheaper cost-effective care (e.g. hip replacement) versus high technology (heart operation)
  → needs to be based on evidence and outcomes
- Pressure to compete economically with U.S. → leads to pressure to emulate other parts of American system → need to resist
- Instead of asking about only needs - ask about what works well
- Look at impacts of health care on other aspects of life
- Front line workers often first to go → impact on quality of care (nurse - laundry)
- Role of volunteer <u>not</u> at expense of formal care
- "Race to the bottom" - part-time, etc.
- Look at innovation in Quebec, etc.
- Not getting to good ideas of front line - not through the organizations that represent them
- See in future increased emphasis on volunteers; policy through stealth, dismantling of today's policies when don't meet future needs
- Increased issues re: personal respect for own health and as volunteer
- Still focusing on deficit reduction

Group 7
Sunday, April 21, 1996

1. Review / Synthesis of Saturday Discussions

- "Private versus public" a lot of discussion at the conference - concern about what this means
- Shift from health care to health - pleased but can't just talk about it - must be done
- Surprised by the consensus
- Consensus on value of system
- Need for balance that is fluid;
  - ↪ equity
  - ↪ needs reform
- Concern that talk was philosophical versus action
- Surprised at morale problem re: professions → mostly medical
- Pleased re: more emphasis on wellness → health → social policies
- More attention paid to cultural aspect
- Values other than North American
- Pleased re: EBDM being addressed
- Health information structure
- Difficult to have universal acceptance definition of evidence
  - ↪ concern that decisions made without evidence
- Accountability - important for everyone to become more of this
  - ↪ patients
  - ↪ providers
  - ↪ suppliers
- Long overdue in health care system
- need fiscal accountability
- need to manage it better
- this will free up resources to do other things
- How will we be able to finance the health system if we don't look for resources elsewhere - privatization may have to be an option
- Devolution to lower level and no accountability at national level
- Community responsibility
- Concern about disparities in health care system for aboriginal community
  - ↪ don't have the best health care system
  - ↪ can't make blanket statement
  - ↪ inequities
- NATIONAL FORUM ON HEALTH has to counteract two tendencies
  - ↪ protect health care system from threats
  - ↪ use balance and evidence
- Potential of health of Canadians going down - such as Eastern Europe
- Forum needs to give messages on health of children, work
- Surprised at the emotion around the drug issue
  - ↪ need to look at accountability
- Concern about losing "universality" when we talk about maintaining health care system - do we mean universality (lost with pensions)

2. Accountability (at all levels)

- Federal government must maintain levers to support five principles of Canada Health Act through effective leverage funding - universality
- If federal government is going to set the rules (goal), provide funding to support services
- Insist that federal government keeps strings attached to funding
- Accountability is devolving down through to the consumer
  - → they need to understand that the system isn't free
  - → consumers need to be accountable
  - → not just responsibility - education is needed to support this paradigm shift
  - → we, as individuals, have to abandon myth that social safety net will look after us
- Federal government must maintain fiduciary role for Aboriginals for health
- Accountability - fiscal, personal, providers, there are many areas
- Federal government's traditional role to maintain Canada Health Act should be maintained, (maintain levers can't decrease transfer payments below current level)
- Need education to promote accountability for other levels / players
- Provincial jurisdictions will be more vulnerable - regions, too, will be vulnerable
- Who will pay for the education required - should not be an add-on, part of all we do
- Can't change society overnight, add course in high schools to educate students about use of system
- Privatization can be a good thing, if federal government has controls, e.g. standards of care
- What is the decision to move to community, based on evidence?
  - → if moving this way, make sure based on evidence
- Decisions are political
- Evidence does exist for the shift, e.g. Queen's Study - problem is how do you do it
- Privatization is another story - looking for new money
- If parallel systems developed public / private - services to public will suffer
- private sector delivers system effectively
- Reinforcement of the need for policy decisions sufficiently tested
  - → learn from experience
  - → system needs to respond
- It's OK to rebalance to the community, but to whom Quebec has CLSC but rest of Canada?
- What is the plan, where is it going? - Provincial Level
  - → needs to be a plan for the shift
- National Forum on Health has to look for other levers - besides $'s - consider "standardization" across the system "PORTABILITY"
- Provincial government has responsibility to manage system - what is federal role?
- The movement that is occurring in the health system is not "political"
  - → the process is politicized
  - → the direction is apolitical
- There is a feeling of erosion of universality

3. Final Thoughts - Advice to the Forum

- Accountability
- Accessibility
- The move forward to health
- Coordination of services of anything that affects health "single point of entry"

Group 8
Sunday, April 21, 1996

1. Review / Synthesis of Saturday Discussions

- Need to protect five principles, while revisiting "medical necessity" - modernizing Canada Health Act
- Enough money in system and leave Canada Health Act alone
- Public sector should have first / equal crack at service delivery
- Concern / questions related to "inevitability" of change and appropriateness of trends
  → e.g. privatization
- Need to consider health aspects of government decisions in non-health sector which affect determinants of health
- Need to base resource allocation on the evidence (apolitical)
- Want rational apolitical decision making
- Don't destroy health care - sick people - while focusing on health - healthy people
- Caution regarding adopting a too strong determinants of health approach
- Regionalization generating concern about maintaining local service

2. Health and Health Care Systems Level Impacts

- Clash between evidence-based medicine and determinants of health → asking for proof of service effectiveness while accepting dogma about determinants uncritically
- Dilemma re: different types of acceptable "evidence"
- Potential conflict between "evidence" and "values"
- Individual versus collective interests / needs
- Potential conflict among all four themes
- Key values being neglected (e.g. choice / personal liberty) which will confound decision making
  → e.g. desire for apolitical decision making versus need for government accountability in potential conflict
- More than one 'solution' and trade-offs needed in balancing the four themes
- Information technological advances makes informing consumer easier
- Develop core principles and service needs and quality
- Need more than lip services to ethno-cultural dimensions and not sure evidence-based approach supports this (need to redirect research)
- Where is the burden of proof
- Will need to face, head on, whether Canadians can buy their way out of downsizing
  → e.g. buy no-longer-insured services

3. New Ideas, Perspectives

- New, different way of fostering funding and directing research
- Downsizing and regionalization is squeezing out research (outcomes research and clinical trials take precedence)
- Should have research re: organization and delivery of services, consumer education, etc.
- Enormous expense re: data systems = need to lower costs of data
- Need better information systems for faster and more appropriate decision making and monitoring
- Need better analysis of changes to identify causes

→ e.g. impact of technology

- Need sufficiently broad assessment of technology (CCOHTA's role)
- What does protect health care in context of health system really mean
- Determinants of health approach has different benefits from health care system
- Regionalization may create care units that are too small
- Conflicting trends of bringing care closer to patient, at same time as knowledge and expertise are increasingly transportable
- Need to combine local primary care resources and national specialty resources
- Need development of ethno-cultural education and needs identification
- Should build information dissemination in new or current databases / systems
  → e.g. central repository for information would improve access to information
- Need to identify and reduce waste
- Need to revisit current activities from determinants of health perspective to improve coordination and eliminate duplication

Other Ideas

- Ontario Ministry of Health AIDS Bureau cultural education / research project
- BC Vancouver - 22 agencies funded to develop culturally sensitive resources
- Downsizing has created defensive posture → need to identify what happens after downsizing and develop a tracking system
- UBC - Therapeutics Initiative is an academic detailing initiative re: prescribing practices (MD-lead)
- Collaborative practice inventory
- Educate consumers
- Community outreach project of Reagent Park Health Centre
- Consumer Health Information Service out of Metro Toronto library
- Westcare Consortium Project → planning for integrated care for area residents

4. Final Thoughts - Advice to the Forum

- Evaluate health policy initiatives
- Make data cheaper and more available
- Empower consumers with more information so they work with providers
- Consumer input in decision making
- Recognize some specialty services are beyond regional or provincial boundaries
- Stronger federal presence in guiding policy development
- Recognize inevitability of trade-offs
- Recognize other values (choice, liberty)
- Need evidence to look at determinants interventions
- Learn from successes elsewhere
  → e.g. Family Violence - Jamaica
- Want policy matrix on how to make resource allocation decisions that balance individual and collective interests / needs

Group 9
Sunday, April 21, 1996

1. Review / Synthesis of Saturday Discussions - Key Messages

- Fiscal restraint is driving this whole process
- Changes in health care are being driven by international harmonization, i.e. trade agreements
- Canadians and health stakeholders don't have a clear vision of where governments are taking us with respect to health system
- Change is also driven by improved utilization of resources
- EBDM is important but only <u>one</u> tool among others - not a panacea
- Fear the debate is happening after the fact →
- Forum appears to be starting with assumption that there is no more money
- Differentiate between cost and price, i.e. drugs utilization is rising
- Use of information and new technology is vital for both education of professionals and the consumer
- Values of Canadians → reflect that a public system is valued more highly than a private / two-tier system
- If federal government is serious about reform of Canada Health Act, "put the money where their mouth is"
  - ↳ re-allocation of money already in system
  - ↳ transfer payments
- Provision of health care is not a commodity → it is a right of citizenship
- Need a national, public system
- Federal role to enforce Canada Health Act = $$$
- Public / patient should be at the centre of the system
- Take step-by-step approach that is evolution, not revolution with evaluation and pilot testing along the way, for example pilot one area in province
- Evolution is <u>already</u> happening → increased cutbacks are heading to the development of a two-tier system <u>now</u>
- Role of Fed's and NFH is diminishing with increased role of provinces
- Changes are being driven by issues that do not reflect the values / will of Canadians
- Fiscal restraint → live with it
- Meet the challenges from within the system not bureaucrats outside

2. Implications for the Future

- Making assumptions of continued fiscal restraint → too short term ?
- Address failings of CHST → the floor is not firm
- Lowering floor decreases the Fed's clout in enforcing the Canada Health Act → is there a hidden agenda ?

Canadian solidarity is falling apart and we are becoming Americanized. This is not what we want → we need leadership.

- We want to retain the Canadian health care system and we want a clear message from government
- See a distinction between not-for-profit and for profit service delivery
- Cutbacks all to be short sighted

- Need to teach healthy physical education in the schools
- Increased costs due to aging population
- Freeze the floor at 1993 levels
- Moneys saved from cutbacks in the health care can be funneled into health
- There are value-based decisions / issues within the system that must be addressed
- Health doesn't come from the health care system →
- Health care is one component of health
- Can't use a illness-based system to produce wellness
- Capital crisis has governments looking for "profit" sources → not looking elsewhere
- Forum put in process / institutions that evaluates effects of government policy and change on health and health care system

Group 10
Sunday, April 21, 1996

1. Review / Synthesis of Saturday Discussions

- Drugs (high cost)
- Freedom of choice in health care
- Support for Canada Health Act; also broadening our discussions of health
- Openness to new ideas
- Importance / awareness of shift towards health, health promotion
- Health system as value-based, people-driven
- Budgets that are more reflective of health goals, with an increased emphasis on primary health care
- Broad concept of health
  - → e.g. employment, children
- Concern that shift to health may impact on health care system
- Canada Health Act a continued framework for discussion

2. Key Messages and Issues

If you were Minister of Health, what would you want to act on?

- Continue to administer health care system and also act as an advocate for health
- Building structures / systems to support shift to community care
- Need a solid evidence-based information system in place - integrating systems
- Bringing a group together with expertise on wellness
- Focus on dissemination of information (and ensure access to information)
- Continue to invest in the future (e.g. health promotion research and development, community development)
- Reassess the concept of comprehensiveness from an evidence-based viewpoint - is it broad enough?
- Implement a National Health Policy / Program - to make the federal government more accountable for certain areas of health (e.g. public health) - the provinces would remain responsible for delivery of health care services

What does the Forum need to do to move this agenda forward?

- Consider developing a framework for Health Policy - health goals, health promotion and prevention, defining what is health?
- Examine / develop criteria for evaluating medicine (traditional and non-traditional) and health care systems
- Get the public to understand the issues (e.g. monthly newsletters to the public and providers); but the onus can't just be on the public to know
- Pull together a group with expertise on sound marketing, health research dissemination

3. New Ideas

- Recommending government reform to a population health focus
  - → e.g. more integration of government departments
- Strategy discussions / the "how to"
- Delivery of the concepts / results of the conference to the public
- We need to respect that people know what they need for health
- Explore what health care system would look like without the current federal / provincial division of responsibilities

4. Final Thoughts - Advice to the Forum

- Maintain our publicly-funded health care system by maintaining (or making less the 72%/ 28% public / private split)
- Guidelines to "strike the balance" between erosion of the system and transformation of the system
- Understand the holistic Determinants of Health
- Strong and specific messages because there is a need for strong leadership
- Ensuring that something happens in the near future
- Strive to maintain policies that encourage openness and that it maintains value accessible across provinces, not only based on cost considerations
- Need better understanding of how health care $'s are being spent in Canada - way budgeting is done doesn't reflect how health care is being delivered
- As we decrease services available, we need to consider whether Canadians should be able to access these services
- Broad ownership and action on the Forum process
- Health care system is a fundamental core value for Canadians
- One health system
- Forum recommendations to be a positive framework with tools . . .

Group 11
Sunday, April 21, 1996

1. Review / Synthesis of Saturday Discussions

- Fair degree of unanimity
  - cautious
  - need to temper positions
  - sensitivity
- Over representation re: "systems approach" arena
- Balanced approach set the tone
- Issues of conflict / definitions caused some confusion
- Sense - a lack of focus - agreement on framework, but what next
- If more time, may have been less consensus
- Confirmation of what already put out

Given the Key Messages:

- What do you see as important implications / impacts at the health system level?
- What are the issues that the Forum should be addressing?

2. Underlying Themes:

1. Better define what universal health, health care is within and for Canada
2. Revisit and fine tune the Canada Health Act
3. Less differentiation between provinces
4. Greater clarify in Canada Health Act on "medical necessity"
5. W..at does comprehensiveness mean - greater clarity
6. Need for strong national standards and federal presence
7. Must support decentralization and creativity at regional levels
8. Mainly health people at Forum - need other major drivers
   - ↪ e.g. "financial representation"
9. "Primary health care must come first" - are we willing to shift our priorities within the system? - need to balance
   - ↪ e.g. health promotion health protection, etc.
10. Live within the "Pot" and need to prioritize, make choices within the resources we have (within the health / health care envelope)
11. Canada Health Act - speak to what is "necessary" for health
12. Need population-based funding and rostering with respect to primary care
13. Policy and financial discussions must interface with political arena
14. Forum must make linkages to bring all together
    - ↪ e.g. "Provincial Policy Forums"
15. Our assumptions about what are realistic will constrain emerging or innovative ideas
16. Forum must put forth its ideas and findings to Canadians

3. What Are the Emerging / Creative and InnovativeIdeas That Can Enhance Canada's Health and Health Care System?

1. Create a mechanism, whenever talking about health / health system, must be tripartite context
    - health
    - income security
    - education
2. Establish service at local level that is multi-linked which depends on clearly defined standards on health and health care
3. Develop a national-link data system with tripartite connection (health, income security, education)
4. Ensure access to evidence (national data system) for making health care decisions
5. Attention paid to those working in the system - re-channel, reinvest and adapt the resources to areas needed in the future
6. Establish some mechanism for human resource planning across the health / health care system (may parallel mechanisms in number1)
7. Establish mandatory rostering
8. Develop a minimum security base to support an inter-provincial approach in health / health care
9. Establish a framework for making choices which address the health needs of the population - "a public framework" by adopting and implementing life cycle planning to enhance population health
10. Look at successful models in all other countries

4. Final Thoughts - Advice to the Forum

1. Try to look at things that are important, not just the urgent needs
2. Need to get the media talking about these issues, not just a "30 second clip". Forum to sensitize the media to the true / real issues.
3. Technology - what implication in health and health care - need to assess re: use / place in a responsible manner. Rapidly emerging and needs attention!

Group 12
Sunday, April 21, 1996

1. Review / Synthesis of Saturday Discussions

- More information on financing of health and health care
- Physician: inadequacies of fee-for-service
- Pharmacy - fee for service inadequate - deficient; explore alternative payment schemes 'Victoria' formula
- Allocation of funding of health in education
- Alternative entry points into system, 'new' access
- Evaluations of existing reforms - impact assessment; effects of health reforms not studied
- Too much focus on acute care within 'health care'
- What is "medically necessary" and what can we afford - not enough discussion
- Human resource development issue to be coupled / partnered with health reform initiatives
- Little emphasis / focus on the 'unpaid' care / labour; health reform increased reliance on these forms of care; long-term repercussions - predominantly women
- Treating people as assets, not liabilities: the human factor of health reform

2. Impacts / Implications

- High stress due to changes / reform
- Ministries must increase work together (different government sectors): also increase cooperation / coordination within health sector; coordinated policies
- Regionalization model within provinces assumed - necessary government devolution of power / authority required for success
- Devolution of power to include those who will manage new system
- Consumers to play increased role
- Health reform to be as broad as possible
- Support and training needed for those affected by health reform, retraining, human capital
- Demoralization exists; no transitional planning for those affected
- Ethics / values to be increased emphasis in provision of health / health care
- Institutional change to community care transition not coordinated; lack of planning - evaluation of changes deficient
- Reality of decreased $'s ≠ poor planning
- Unrealistic that resource reallocation can be apolitical; political reality reality check
- Human resource / labour relation issues should not be lost in health reform equation
- Increased accountability - public elections - of regional boards / structures
- Need to increase focus on wider determinants of health - especially children - importance of early childhood development; changes to Canada Pension Plan
- Double prevention 'moneys'
- Increase debate on what is funded - medically necessary; patchwork across country if left to provinces
- Better understanding of "medically necessary"
- Consult public on issue of "medically necessary"; land mine issue but discussion needed
- 'Framework' for understanding of "medically necessary"
- Better management of consumer expectations

- Jurisdictional / provincial variation in what is medically necessary makes consensus very difficult
- It is necessary to 'medicalize' this practice / procedure; in other words, what is meant by the term

Medically Necessary:

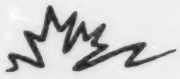
- Ethical issues inherent
- Cultural considerations
- Look at term 'medically'; broaden understanding to include proper nutrition for children
- Broader vision of health should not be lost - not simply health care
- Evidence based? Medicalization?
- Guidelines required
- Funding context not helpful when discussing issue
- Increase broader context of what is "medically necessary" could lead to increased confusion - disaster
- "Wellness" loses to the care / treatment side
- Consult public on issue; input required
- Examine origins / purpose of Canada Health Act
- Discussion of medically necessary not to be framed in terms of funding - move away from this orientation

3. Creative Thought

- Public health / health care - education required - soon
- - extensive
- Give Feds. health and education jurisdiction; create regional boards
- Doctor remuneration to be addressed
- Include children in service delivery of health / health care
- Address the existing fear / stress of health reform; presentation of system
- Look at our expectations, our rights
- Policy / program planning to include the 'unpaid' human capital - labour force
- Increase creativity of true partnerships - private sector - to get better value for $

4. Final Thoughts - Advice to the Forum

- Women's use of system to be qualified and explained; bare statement of women as greatest users not sufficient / acceptable
- Implement some of the recommendations of Forum
- People / public to drive the process
- Urban- rural disparity to be addressed



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